



PATIENT INFORMATION

*Last Name		*First Name		*Middle Name or Initial	
*Social Security Number ____ - ____ - ____		*Date of Birth (MM/DD/YYYY) ____ / ____ / ____		*Sex (Check One) ____ Female ____ Male	
Marital Status (Check One) ____ Single ____ Married ____ Domestic Partnership ____ Legally Separated ____ Widowed		Employment Status (Check One) ____ Full-Time ____ Part-Time ____ Self-Employed ____ Retired ____ Active Military ____ Unemployed		If Post Secondary School Student Status 18 years old and older (Check One) ____ Full-Time ____ Part-Time Name of School _____	
*Mailing Address		*City		*State	*Zip Code
*Preferred Phone Number ()		Home Phone Number ()		Work Phone Number ()	
Cell Phone or Pager Number ()		E-mail			

MEDICAL HEALTH INSURANCE INFORMATION

*Primary Insurance Company		*Group Number		*Subscriber Number	
<i>Subscriber Name (If patient is not the subscriber)</i>		<i>Subscriber's Social Security Number (If patient is not the subscriber)</i> ____ - ____ - ____		Patient's Relationship To Insured (Check One) ____ Self (Patient is the Subscriber) ____ Spouse/Domestic Partner ____ Parent/Legal Guardian ____ Other	
<i>Subscriber's Sex (Check One)</i> ____ Female ____ Male		<i>Subscriber's Date of Birth (If patient is not the subscriber) (MM/DD/YYYY)</i> ____ / ____ / ____			
<i>Insurance Subscriber's Mailing Address, City, State, & Zip Code (If different from patient's mailing address)</i>					
<i>Insurance Subscriber's Phone Number</i> ()			<i>Insurance Subscriber's E-mail</i>		
Secondary Insurance Company (If applicable)				Group Number	
Tertiary Insurance Company (If applicable)				Group Number	
Patient or Insurance Subscriber's Employer Name or Company				Employer's Address	

IN CASE OF EMERGENCY

DESERT FAMILY MEDICAL CENTER WILL CONTACT ON PATIENT'S BEHALF THE FOLLOWING INDIVIDUAL

*Name (First and Last Name)	Preferred Phone Number ()	Relationship to Patient
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The above information provided by me is attested to be true. I authorize my insurance benefits to be paid directly to Erik G. Palmer, D.O., A Medical Corporation dba Desert Family Medical Center. In understand that I am financially responsible for any and all balances that my insurance company does not cover. In signing this statement, I authorize Erik G. Palmer, D.O., A Medical Corporation dba Desert Family Medical Center or my insurance company to release any information required to process my medical health insurance claim(s).

Patient or Parent/Guardian Signature

Date