

# DESERT FAMILY

MEDICAL CENTER

## Patient Information Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth\* (MM/DD/YY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Sex\*: Female / Male Student Status: Full-time / Part-time / not a student

Marital Status (circle one): Married / Single / Divorced / Legally Separated / Widowed / Domestic Partner

Employment Status: Full-time / Part-time / Self-employed / Not employed / Retired / Active Military

Street Address or P.O. Box:\* \_\_\_\_\_

City\* \_\_\_\_\_ State\* \_\_\_\_\_ Zip/Postal Code\* \_\_\_\_\_

Home Phone\* ( ) \_\_\_\_\_ Cell Phone/Pager ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ ext. \_\_\_\_\_ e-mail \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance† \_\_\_\_\_

Secondary Insurance† \_\_\_\_\_ Tertiary Insurance† \_\_\_\_\_

Insurance Name\*: \_\_\_\_\_

Insurance ID\*: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

Patient's Relationship to Insured: \_\_\_\_\_

Insured Name (if different than patient)\* \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Sex: M / F Date of Birth\*: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Phone\*: ( ) \_\_\_\_\_

Insured Address\*: \_\_\_\_\_

City/State\*: \_\_\_\_\_ Zip\*: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

### IN CASE OF EMERGENCY

Name of relative or friend: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for my balance. I also authorize Desert Family Medical Center or insurance company to release any information required to process my claims.

Patient/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

\*Required field