TOTAL CARE FAMILY MEDICAL CENTER

Date:_____

PATIENT INFORMATION

Patient Name:(First Middle Last)		Sex: M__ F___ Age:	Date of Birth:
Primary Care Physician:	Marital Status: S___M___W___D___		SSN:
Reason For Visit:	Race:	Ethnicity:	Language(s) Spoken:
Address:	City:	State:	Zip:
Home Phone	Work Phone#	Cell Phone#	
Email Address 1:	Email Address 2:		
Patient's Employer:		Bus. Phone#	
Employer Address:		Driver's License #	State
Pharmacy:	Address:	Phone#	
Referred by:	Is this your First Visit? Yes No		

CONTACT INFORMATION

EMERGENCY Contact Name:		**EMERGENCY Phone Number:**
(Friend or relative not living with you)(Please complete)	Relationship:	**Cell Phone#**

RESPONSIBLE PARTY (OR SPOUSE OR PARENT INFORMATION)

Name:	D.O.B.	Cell Phone:
Employer:		Work Phone:
Relationship to Patient:	Soc. Sec#	Driver's License # State

INSURANCE INFORMATION

Insurance Name:		Copay amount $	
Claims Address:			Phone#
Subscriber Name:	D.O.B.	S.S.#	
Relationship to Patient:	Policy #		Group #
Secondary Insurance Name (If applicable)			
Claims Address			Phone#
Subscriber Name	D.O.B.	S.S.#	
Relationship to Patient:	Policy #		Group #

****Please give receptionist your insurance card to scan. Thank You.****

AUTHORIZE/CONSENT

I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgement of the physician. I hereby authorize the physician to release any information acquired in the course of my examination or treatment. I hereby authorize payment directly to the physician of benefits otherwise payable to me for his services unless services are paid in full when rendered. I also give my consent for the staff to obtain medication history electronically.

Signed_____
(Parent or guardian must sign if patient is a minor.)

Relationship to Patient_____
(Self, Mother, Father, etc.)

Date_____

Witness_____