ORION
Family Physicians

PATIENT INFORMATION

NAME (LAST):_____ (FIRST):_____ (MI): _____

ADDRESS: _____

CITY, STATE, ZIP CODE:_____

ALT ADDRESS:_____

CITY, STATE, ZIP CODE:_____

Mobile:_____ Phone:_____ Work: _____

SS#_____ Date of Birth_____ Fax:_____

Sex: M F

Martial Status: Single Married Divorced Widowed Separated Other

Race: Black/African American Hispanic Native American Asian White Chinese Filipino
Japanese Native Hawaiian Multiracial Pacific Islander Other

Language: _____

Employment Status: Full-Time Part-Time Self-Employed Retired Student Child Unemployed Other

EMPLOYER: _____

EMERGENCY CONTACT

NAME: PHONE: _____

RELATIONSHIP:

Mobile:_____ Phone:_____ Work: _____

INSURANCE

INSURANCE NAME (PRIMARY):_____

INSURED NAME:_____ MALE____ FEMALE___

ADDRESS: _____

CITY, STATE, ZIP CODE:_____

PHONE:_____ RELATIONSHIP TO PATIENT: _____

SS#_____ Birthdate: _____

AMOUNT OF OFFICE CO-PAY:_____

INSURANCE NAME (SECONDARY):_____

INSURED NAME:_____ MALE____ FEMALE___

ADDRESS: _____

CITY, STATE, ZIP CODE:_____

PHONE:_____ RELATIONSHIP TO PATIENT: _____

SS#_____ Birthdate: _____

PERSON RESPONSIBLE FOR ACCOUNT - PATIENT IS RESPONSIBLE IF OVER 18

NAME:_____

ADDRESS: _____

CITY, STATE, ZIP CODE:_____

PHONE:_____

SS#_____ BIRTHDATE: _____

I request payment of authorized medical benefits to be made on my behalf to Orion Family Physicians. I authorize any medical information needed to determine benefits payable to be released to my insurance company or its' agent. Further, I understand that any service not covered by my insurance will be come my full responsibility, and is due and payable by me. I also certified that the above information is correct.

PRIVACY NOTICE

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

Acknowledgement:

I acknowledge that i have received the NOTICE OF PRIVACY PRACTICES.

_____

Patient Name (Please Print)

_____

Date

_____

Patient or Personal Representative (Signature)

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____