FIRSTCARE

(A division of Glendale Family Medicine, PC)

Social Security # _____/_____/_____
First Name _____
Last Name _____
Middle Name _____
Date of Birth _____/_____/_____
Sex [ ] Female [ ] Male
Address: _____
Zip Code: _____
City: _____
State: _____

Home Phone (____)_____
Cell phone (____)_____
E-Mail _____
Do you want Information E-Mails? [ ]Yes [ ]No
Best contact means: [ ] cell [ ] home [ ] E-mail
Marital Status _____
Employment: [ ]Full [ ]Part [ ]Not [ ]Disabled
Race: [ ] White [ ] Black [ ] Asian
Ethnicity: [ ]Non-Hispanic [ ]Hispanic
Preferred Language _____

EMERGENCY CONTACT NAME: _____ **PHONE :**_____

How did you hear about us? [ ] Already a patient [ ]Friend [ ]Relative [ ]Another Patient [ ]Advertising
[ ]ZocDoc [ ]Insurance Directory [ ]Signage [ ]Saw the Building [ ]Which Web Site? _____

PHARMACY INFO: Name:_____ Address: _____ Zip: _____

INSURANCE COMPANY INFORMATION:

Primary Insurance : _____
Address: _____
Zip: _____ Card #: _____

Phone: (____)_____
City: _____State:_____
Group #: _____

Secondary Insurance : _____
Address: _____
Zip: _____ Card #: _____

Phone: (____)_____
City: _____ State:_____
Group #:_____

EMPLOYMENT INFORMATION:

Where do you work?: _____ Phone: (____)_____
Company Address:_____
City: _____ State: _____ Zip: _____

Is this a job related injury? []No []Yes

BILLING INFORMATION:

Who is responsible for paying this bill? [ ] The Patient above [ ] The Person below

Payer's Last Name:_____
First Name: _____ M.I._____
Street Address: _____
City: _____ State: _____
Zip Code: _____ Sex [ ] Female [ ] Male

Home Phone: (____)_____
Work Phone: (____)_____
Date of Birth: ___/___/___ Age:____
Social Security #: _____-____-_____
Marital Status:_____

I hereby authorize the release, to my insurance company, of any information acquired during the course of my examination or treatment and authorize my insurance company to make direct payment to First Care, a division of Glendale Family Medicine, PC. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I also agree to pay any and all collection fees incurred and interest at a rate of 21% APR for balances on my account beyond 30 days. I acknowledge a processing fee of $35 for each co-payment not collected at the time of the visit that must be billed to me. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. It is my responsibility to advise *Firstcare*, a division of Glendale Family Medicine, PC of any changes in my health status, or any of the above information.

Signed: _____ Date: _____/_____/_____