ProHealth Family Physicians

PATIENT INFORMATION

Patient Account #

Name:	**Date of Birth:**
Address One:	**Social Security #:**
	Sex:
City:	**Language:**
State: **Zip:**	**Employer:**
Home Phone#:	**Emergency Contact:**
Work Phone#:	**Emergency Phone#:**
Cell Phone#:	**Emergency Relationship:**
Email:	**Ethnicity:** **Race:**

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	**Email Address:**
City:	**Employer:**
State: **Zip:**	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:** **Zip:**
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Subscriber ID:	**Subscriber ID:**
Group Number:	**Group Number:**
Co-pay:	**Co-pay:**
Subscriber Name:	**Subscriber Name:**
Subscriber SS#:	**Subscriber SS#:**
Subscriber DOB:	**Subscriber DOB:**

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider at ProHealth Family Physicians when he/she accepts assignment.

Authorization To Release Medical Information. I hereby authorize my provider at ProHealth Family Physicians to release information to any provider and to obtain Prescription History from pharmaceutical providers necessary for my course of treatment.

Waiver for Potentially Non-Covered Services: I am aware in the event the services/procedures performed are not a covered benefit with my insurance company; I am responsible for the charges.

Payments: All payments are expected at the time of service, such as copayments, deductibles & coinsurance.

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Signed (patient or parent if minor) Date