COLLINS MEDICAL ASSOCIATES 2 PC

PRIMARY CARE PROVIDER	
REFERRED BY	

DATE	NEW ❑ UPDATE ❑
PHARMACY NAME	**PHARMACY PHONE**

PATIENT INFORMATION   Acct Number

LAST	FIRST	MI.	BIRTHDATE	SEX M ❑ F ❑
ADDRESS	CITY	STATE	ZIP	MARITAL STATUS

HOME PHONE	WORK PHONE
CELL PHONE	EMAIL ADDRESS

PATIENT SOCIAL SECURITY #	Preferred Contact Phone

RACE ❑ AMERINDIAN   ❑ BLACK   ❑ HISPANIC   ❑   ASIAN   ❑ WHITE

ETHNICITY ❑ HISPANIC   ❑ NON-HISPANIC   PREFERRED LANGUAGE:

EMPLOYER/SCHOOL	OCCUPATION

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	START DATE

NEXT OF KIN/EMERGENCY CONTACT	RELATIONSHIP	PHONE

PARENT/GUARANTOR INFORMATION- PERSON FINANCIALLY RESPONSIBLE FOR BILL

LAST	FIRST	MI.	❑ PARENT (IF PATIENT A MINOR) ❑ SPOUSE ❑ OTHER _____	BIRTHDATE

ADDRESS (IF DIFFERENT FROM PT.)	CITY	STATE ZIP	SOCIAL SECURITY #

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS

EMPLOYER/SCHOOL	OCCUPATION

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	START DATE

INSURANCE INFORMATION   Please complete all information to ensure accuracy in claim submission

INSURANCE COMPANY #1	POLICY/MEMBER ID #	GROUP #	COPAYS SPEC . $ PRIM . $
POLICY HOLDER ADDRESS (IF DIFFERENT) SSN			RELATION TO INSURED ❑ SELF ❑ SPOUSE
DOB CITY ST ZIP			❑ CHILD ❑ OTHER
INSURANCE COMPANY #2	POLICY/MEMBER ID #	GROUP #	COPAYS SPEC . $ PRIM . $
POLICY HOLDER ADDRESS (IF DIFFERENT) SSN			RELATION TO INSURED ❑ SELF ❑ SPOUSE
DOB CITY ST ZIP			❑ CHILD ❑ OTHER

INJURY INFORMATION

IS INJURY   ❑ WORK RELATED   ❑ AUTO RELATED   CLAIM #_____   DATE OF INJURY   /   /

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONS IBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND PRACTICE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PA ID DIRECTLY TO THE PRACTICE OR ITS REPRESENTATIVE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO CONTACT MY INSURANCE AND PRIMARY CARE PROVIDER TO ENSURE THAT ANY REQUIRED REFERRALS ARE INITIATED. I UNDERSTAND THAT ALL SERVICES NOT COVERED BY MY INSURANCE WILL BE MY RESPONSIBILITY.

PATIENT/GUARANTOR SIGNATURE _____   *DATE* _____

(PARENT IF PATIENT IS A MINOR)