WEBSTER
FAMILY CARE

PATIENT INFORMATION

Today's date: _____ PCP: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.

Marital status (circle one)
Single / Mar / Div / Sep / Wid

Birth date: _____ Age: _____ Sex: _____ Cell Phone No.: _____

Street address: _____ Social Security no.: _____ Home phone no.: _____

P.O. box: _____ City: _____ State: _____ ZIP Code: _____

Occupation: _____ Employer: _____

Other family members seen here: _____

INSURANCE INFORMATION

IF YOUR NEW BORN IS UNDER YOUR INS. PLEASE PUT YOUR INFO. HERE _____ (PLEASE GIVE OFFICE YOUR INS. CARD)

Person responsible for bill: _____ Birth date: ___ /___ /_____ Address (if different): _____ Home phone/Cell phone: (———)_____

Primary insurance Name : _____

Member ID : _____

Subscriber's name: _____ Subscriber's S.S. no.: _____ Birth date: ____ /___ /____ Group no.: _____ Policy no.: _____ Co-payment: $ _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): _____ Subscriber's name: _____ Group no.: _____ Policy no.: _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____ Relationship to patient: _____ Home phone no.: (———)_____ Work phone no.: (———)_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____

Patient/Guardian signature *Date* _____