SPRINGTOWN FAMILY
HEALTH CENTER

PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____ Social Security #:_____
Address:_____ City:_____ State:_____ Zip Code:_____
E-Mail Address:_____
Cell Number:_____ Work number:_____
Sex: ( ) Male, ( ) Female ( ) Married ( ) Single ( ) Divorced ( ) Employed ( ) Retired ( ) Full Time Student
Pharmacy:_____

RESPONSIBLE / INSURED PARTY

( ) Same as above ( ) Husband ( ) Wife ( ) Mom ( ) Dad ( ) Other:_____
Patient Name:_____ Date of Birth:_____ Social Security #:_____
Address:_____ City:_____ State:_____ Zip Code:_____
E-Mail Address:_____
Cell Number:_____ Work number:_____
Sex: ( ) Male, ( ) Female

PRIMARY INSURANCE INFORMATION

Name of Insurance Company:_____
Name of Insured Person:_____ Date of Birth:_____ Social Security #:_____
Employer:_____ Employer Phone #:_____
Relationship to patient : ( ) Husband ( ) Wife ( ) Son ( ) Daughter ( ) other
Insurance Effective Date:_____
Member ID #;_____ Group #:_____ Copay $:_____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company:_____
Name of Insured Person:_____ Date of Birth:_____ Social Security #_____-_
Member ID #;_____ Group #:_____ Copay $:_____

EMERGENCY AND HIPPA CONTACT INFORMATION

1. Name:_____ Relationship;_____
   Contact Number:_____
2. Name:_____ Relationship;_____
   Contact Number:_____
3. Name:_____ Relationship;_____
   Contact Number:_____

I hereby authorize my insurance benefits to be paid directly to Springtown Family Health Center (Dr. Gene McDaniel / Dr. Chris Opella), realizing I am responsible to pay any and all non-covered services. I authorize the release of any pertinent medical information to insurance carriers and I hereby state that all information given on this form is correct and true. I also understand that Springtown Family Health Center files my insurance as a courtesy to me, and any incorrect or falsified information given will terminate such courtesy and payment will be due in full at the time of service. All payments are rendered at the time service unless arrangements have been made.

_____ _____
Patient/ Guarantor Signature Date