Methodist FAMILY HEALTH CENTERS

**PATIENT INFORMATION**

| | | | |
|---|---|---|---|
| Name | | Date of Birth | Sex |
| Address | City | State | Zip |
| Home Phone | Work | Cell | |
| Email Address | | **Social Security Number** | |
| Preferred Pharmacy (Name / Address / Phone Number): | | | |
| Employer Name and Address: | | Student Status: ○ Full Time ○ Part Time ○ N/A | |
| Race ○ Black/African American ○ Asian ○ Caucasian ○ Hispanic or Latino ○ Other (*Please Specify)* | | | |
| Ethnicity: ○ Hispanic or Latino ○ Not Hispanic ○ Decline to Provide | | Marital Status ○ Single ○ Married ○ Divorced ○ Widowed/Widower | |
| Primary Language Spoken in the Home ○ English ○ Spanish ○ Other (please define): | | | Veteran ○ Yes ○ No |

**RESPONSIBLE PARTY/GUARANTOR INFORMATION IF DIFFERENT FROM ABOVE**

| | | | |
|---|---|---|---|
| NAME | Date of Birth | Relationship to Patient | |
| Address | City | State | Zip |
| Phone Home/Cell | Work | **Social Security Number:** | |

**PRIMARY INSURANCE**

| | | | |
|---|---|---|---|
| Insurance Company Name | | Phone Number | |
| Policy Number/Member ID Number | Group Number | | |
| Address | City | State | Zip |
| **Name of Insured** **Date of Birth** | Relationship to Patient ○ Self ○ Spouse ○ Parent ○ Other | | |

**SECONDARY INSURANCE IF APPLICABLE**

| | | | |
|---|---|---|---|
| Insurance Company Name | | Phone Number | |
| Policy Number/Member ID Number | Group Number | | |
| Address | City | State | Zip |
| Name of Insured Date of Birth | Relationship to Patient ○ Self ○ Spouse ○ Parent ○ Other | | |

**HOW DID YOU HEAR ABOUT US?**

○ Existing Patient (*Please Specify)* _____ ○ Family Referral(*Please Specify)* _____

○ Insurance ○ Billboard/Drive By ○ Employee ○ Direct Mail ○ Hospital Referred ○ Internet ○ Living Magazine ○ Other _____

Which lab is your insurance co. contracted with? ○ LabCorp ○ Quest ○ CPL ○ Other (please define): _____

Please note, that we may draw labs in the office; however, it is your responsibility to know which lab your insurance co. is contracted with. Please call your insurance co. prior to having blood work drawn to make sure that they will cover testing for the appropriate CPT codes. We are not responsible for third party bills related to services rendered.

I certify that I have carefully reviewed this document, understand and have filled out truthfully.

_____ _____

Signature of Patient or Guardian (Relationship to Patient, If not signed by the Patient) Date