

GLENDALE FAMILY MEDICINE, PC

Social Security # _____ / _____ / _____
First Name _____
Last Name _____
Middle Name _____
Date of Birth _____ / _____ / _____
Sex Female Male
Address: _____
Zip Code: _____
City: _____
State: _____
How did you hear about us? Friend Relative Another Patient Advertizing ZocDoc
 Insurance Directory Signage Saw the Building Which Web Site? _____

Home Phone (____) _____
Cell phone (____) _____
E-Mail _____
Do you want Information E-Mails? Yes No
Best contact means: cell home E-mail
Marital Status _____
Employment: Full Part Not Disabled
Race White Black Asian Decline
Ethnicity Non-Hispanic Hispanic
Preferred Language _____

INSURANCE COMPANY INFORMATION:

Primary Insurance : _____
Address: _____
Zip: _____ Card #: _____
Secondary Insurance : _____
Address: _____
Zip: _____ Card #: _____

Phone: (____) _____
City: _____ State: _____
Group #: _____
Phone: (____) _____
City: _____ State: _____
Group #: _____

EMPLOYMENT INFORMATION:

Where do you work?: _____ Phone: (____) _____
Supervisor's Name: _____ Your employee ID #: _____
Company Address: _____
City: _____ State: _____ Zip: _____

Is this a job related injury? No Yes - Have you notified your boss? No Yes

BILLING INFORMATION:

Who is responsible for paying this bill? The Patient above The Person below

Payor's Last Name: _____
First Name: _____ M.I. _____
Street Address: _____
City: _____ State: _____
Zip Code: _____ Sex Female Male

Home Phone: (____) _____
Work Phone: (____) _____
Date of Birth: ____ / ____ / ____ Age: ____
Social Security #: _____ - _____ - _____
Marital Status: _____

I hereby authorize the release, to my insurance company, of any information acquired during the course of my examination or treatment and authorize my insurance company to make direct payment to Glendale Family Medicine, PC. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I also agree to pay any and all collection fees incurred and interest at a rate of 21% APR for balances on my account beyond 30 days. I acknowledge a processing fee of \$35 for each co-payment not collected at the time of the visit that must be billed to me. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. It is my responsibility to advise Glendale Family Medicine, PC of any changes in my health status, or any of the above information.

Signed: _____ Date: _____ / _____ / _____