PACIFIC GROVE FAMILY MEDICINE

Name_____ **DOB**_____
Last Name First Name Middle Initial

Sex: Male/Female **Social Sec #**_____ **Married ____Single____Widowed____Divorced____Minor____**

Street Address_____**City**_____**State**_____**Zip**_____

Home Phone #_____ **Cell Phone #** _____**Work #** _____

Email : _____**Preferred Language (If not English)**_____

Mailing Address (if different) _____

Parent's Name (if minor)_____ **Social Sec #** _____ **DOB**_____

Emergency Contact_____ **Relationship to Patient** _____

Primary Phone # _____ **Alt. Phone #** _____

Race:African-Amer___Asian___Caucasian___Hispan___Native-Amer.__Pacif Islan.___Other___Decline___

Primary Insurance

Person responsible for account (Primary Insured/Sponsor) _____
Last Name First Name Middle Initial

Relation to patient_____**Birthdate**_____**Social Security #**_____

Address (If different from patient's)_____ **Phone #**_____

City _____ **State**_____ **Zip**_____ **Work #**_____

Insurance Company/Branch of Service_____

Subscriber ID #_____ **Group #** _____

Additional Insurance

Person responsible for account _____
Last Name First Name Middle Initial

Relation to patient_____**Birthdate**_____**Social Security #**_____

Address (If different from patient's)_____ **Phone #**_____

City _____ **State**_____ **Zip**_____ **Work #**_____

Insurance Company_____

Subscriber ID #_____ **Group #** _____

Assignment and Release

I hereby consent for treatment and give authorization for payment of insurance benefits to be made directly to Pacific Grove Family Medicine, Inc. for services rendered. The above information I have provided is current and accurate to the best of my knowledge. I understand that I am financially responsible for all charges should my insurance company deny my claim. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I authorize the use of my signature on all of my insurance claim forms. I agree that certain samples or specimens may be sent out for further testing and I may receive a separate bill for these services. I am aware that there is a $50.00 fee if 24 hour notice is not given for cancellation of appointments.

Signature _____**Relationship to patient** _____**Date**_____