



# Patient Demographic & Insurance Information

## Basic Patient Information

Patient's Social Security Number: \_\_\_\_\_

Name of Patient

First

Middle

Last

Birth Date

Gender F M

Street Address

City

State

Zip

Home Phone ( )

Work Phone ( )

## Patient's Relationship to Insured?

Self

Child

Spouse

Guardian

Other

**Please present your insurance card to the front desk receptionist when returning this form**

## Billing Information/Responsible Party/Guarantor for Encounter

Name of Insured

First

Middle

Last

Street Address

City

State

Zip

Birth Date

Guarantor's Social Security Number: \_\_\_\_\_

Gender

F

M

Home Phone ( )

Work Phone ( )

Guarantor's Employer

## Insurance Coverage - Primary

Name of Insurance

Policy Number

Effective Date: (if applicable)

Group Number

Primary Care Physician

Name of Insured

First

Middle

Last

Birth Date

Retire Date (if applicable)

Gender

F

M

Phone ( )

Name of Insured's Employer

Address of Insurance Holder

(If different than Patient Address)

City

State

Zip



# Patient Demographic & Financial Responsibility Acknowledgement

## Insurance Coverage - Secondary

**Name of Insurance** \_\_\_\_\_

**Policy Number** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

**Group Name** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_

**Name of Insured** \_\_\_\_\_

First

Middle

Last

**Birth Date** \_\_\_\_\_

**Retire Date** (if applicable) \_\_\_\_\_

**Gender**

F

M

**Phone**

(      )

**Name of Insured's Employer** \_\_\_\_\_

**Address of Insurance Holder** \_\_\_\_\_

(If different from Patient Address) \_\_\_\_\_

**City** \_\_\_\_\_

**State** \_\_\_\_\_

**Zip** \_\_\_\_\_

## Additional Patient Information

**Marital Status**

Single

Married

Divorced

Separated

**Patient's Employment Status**

Full-Time

Part-Time

None

**Spouse's Employment Status**

Full-Time

Part-Time

None

**Student Status (If Applicable)**

Full-Time

Part-Time

None

Did you bring with you today the written referral form from your Referring Physician?

YES

NO

**Referral Physician** \_\_\_\_\_

## Emergency Contact Information - Primary Contact

**Name** \_\_\_\_\_

**Relationship to patient** \_\_\_\_\_

**Home Phone** (      ) \_\_\_\_\_

**Work Phone** (      ) \_\_\_\_\_

**Street Address** \_\_\_\_\_

**City** \_\_\_\_\_

**State** \_\_\_\_\_

**Zip** \_\_\_\_\_

**Notes/Special Directions** \_\_\_\_\_

## Financial Responsibility Agreement

I/We hereby authorize Trinity Family Medical Center to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment of medical benefits to Trinity Family Medical Center and further understand that should my account have to be referred to an attorney for collection that I am responsible for all fees and costs incurred therein. I/We hereby authorize Trinity Family Medical Center to act on my behalf in accessing hospital medical records when and if needed.

Date \_\_\_\_\_

Patient or Guardian Signature \_\_\_\_\_



# Patient Medical History

**Patient Name:** \_\_\_\_\_

**Patient Age:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **BMI:** \_\_\_\_\_ **Frame:** \_\_\_\_\_

## DESCRIBE YOUR PROBLEM OR INJURY:

Date of onset of the problem: \_\_\_\_\_ Name of Primary Care Physician: \_\_\_\_\_

Name(s) of Other Physician(s) you are currently seeing: \_\_\_\_\_

## PAST MEDICAL HISTORY

Please list all previous operations

Surgery	Approximate Date of Surgery	Name of Surgeon	Hospital Where Performed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Major Medical Problems:

Please check if you are currently receiving treatment or have received treatment in the past for any of the following conditions:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Currently Pregnant   | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Bleeding Disorders   | <input type="checkbox"/> Cancer                        | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Diabetes        |
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Hepatitis                     | <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> Asthma          |
| <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Phlebitis (blood clots)       | <input type="checkbox"/> Thyroid Disease      | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Scarlet Fever        | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Birth Defects        | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Intestinal Disorders | <input type="checkbox"/> Other (Please Specify) _____  |   |  |

## MEDICATIONS

Are you taking any prescriptions or over-the-counter medications?  YES  NO

If yes, please list medications below:

Medication	Dosage	How long have you been taking this medication?	Name of Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## DRUG ALLERGIES

Please list any drugs/substances to which you have had a reaction, and describe your physical reaction

Drug/Substance	Physical Reaction
_____	_____
_____	_____
_____	_____