5 Star Family Medicine

PATIENT INFORMATION

DOB (mm/dd/yyyy) / /

Gender ◉ M ○ F

Social Security No.

Patient ID #: NEW

Salutation | **Last Name** | First Name | MI | Suffix (JR, SR, III)

Patient Address

City | State | Zip

Home Phone

Work Phone

Cell Phone

Email

Patient Photo — 2 X 2 Photo — Add Pic

Marital Status: ○ Single ○ Married ○ Other

Partner Name

Employer Name

Emergency Contact Name

Emergency Contact Phone

I Will be paying today by: (Please Check One Box)

☐ Having 5 Star Family Medicine file my insurance for me and I will pay my COPAY today.

☐ Paying for my office visit today with Cash, Check, or Credit Card.

I authorize the release of any medical information necessary to process claims and irrevocably assign to 5 Star Family Medicine all payments for services rendered. I understand that I am ultimately responsible for the balance of my account, whether or not any of the professional services rendered are covered by my insurance. I understand that my appointment will need to be rescheduled if I do not have my COPAY, my insurance information, or payment for my office visit today. I certify that this information is true and correct. I have received a copy of the Privacy Notice and have had an opportunity to object to the disclosures of my health care information.

_____/_____

SIGNATURE (if minor, Parent's Signature)/ **DATE**

Thank you for choosing 5 Star Family Medicine!