Providence Medical Group

Primary Care Physician_____ Referring Physician_____

Updated:

PATIENT INFORMATION

Last Name: First: MI: DOB: Age: Gender:

Address: City: State/Zip:

Home and/or Cell Phone # Social Security #

Martial Satus: ◯Single ◯Married ◯Partner ◯Widowed ◯Divorced ◯Separated

Responsible Party: (if other than patient) | Relationship to Patient:

Race: ◯ White ◯Asian ◯African American ◯American Indian or Alaska Native ◯Native Hawaiian or other Pacific Islander ◯Other ◯Refused to Report

Ethnicity: ◯ Hispanic or Latino ◯Not hispanic or Latino ◯Refused to report

Primary language: ◯English ◯Spanish ◯Other _____ Interpreter needed? ◯Yes ◯No

Employer | Email Address for Web Portal:

Pharmacy of Choice and Location: | Emergency Contact and Phone Number:

How would you like to receive appointment reminders: ◯Home number ◯ Cell number ◯Text message

HEALTH INSURANCE***

Primary Insurance: Secondary Insurance:

ID # Group # ID # Group #

Policy Holder: Policy Holder:

*****If you do not present a copy of your insurance card, you will be responsible for all office and surgery charges incurred until we receive a copy of the front and back of the card(s).**

Insurance Policy Holder (other than self)

Name: DOB: SSN:

Address: City: State/Zip

Home Phone | Cell Phone | Work Phone

Relationship to Patient: Employer:

Insurance Authorization & Assignment/Consent to Treatment: I hereby authorize Providence Medical Group to furnish information to insurance carriers concerning my dependents illness or myself and treatments and I hereby assign to the physician (s) all payments for medical services to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. **(Must be signed regardless of insurance coverage)**

Signature Date

Lifetime Consent - Medicare Patients Only: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Providence Medical Group for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the healthcare financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature Date