



# PUTNAM NORTH FAMILY MEDICAL

## PATIENT DEMOGRAPHICS



PATIENT NAME:		Physician you are seeing:		ACCT #
DATE OF BIRTH:		SS#		SEX:
HOME PHONE:		CELL PHONE:		E-MAIL ADDRESS
ADDRESS:		CITY:	STATE:	ZIP:
PATIENT'S EMPLOYER:			WORK PHONE:	
MARITAL STATUS:			SPOUSE'S NAME:	
SPOUSE'S WK PHONE:			NEXT OF KIN (OTHER THAN SPOUSE):	
NEXT OF KIN PHONE:			RELATIONSHIP:	
EMERGENCY CONTACT:			PHONE:	

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN WHO PERFORMED THE MEDICAL SERVICE AND THE RELEASE OF ANY MEDICAL, PSYCHIATRIC OR OTHER INFORMATION NECESSARY TO PROCESS ALL INSURANCE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY PORTION OF MY BILL NOT COVERED OR DEEMED NOT MEDICALLY NECESSARY, INVESTIGATIONAL OR EXPERIMENTAL BY MY INSURANCE COMPANY. A PHOTOSTAT OF THE AUTHORIZATION SIGNATURE IS AS VALID AS THE ORIGINAL.

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

PRIMARY INSURANCE:		SUBSCRIBER'S NAME:		
SUBSCRIBER'S SSN:	RELATIONSHIP TO SUBSCRIBER:	SUBSCRIBER'S DOB:		
POLICY ID / GROUP:		SUBSCRIBER'S EMPLOYER:		COPAY:
LIST OTHER PERSONS COVERED:				EFFECTIVE DATE :

SECONDARY INSURANCE:		SUBSCRIBER'S NAME:		
SUBSCRIBER'S SSN:	RELATIONSHIP TO SUBSCRIBER:	SUBSCRIBER'S DOB:		
POLICY ID / GROUP:		SUBSCRIBER'S EMPLOYER:		COPAY:
LIST OTHER PERSONS COVERED:				EFFECTIVE DATE:

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL, PSYCHIATRIC OR OTHER INFORMATION TO THE PERSON(S) LISTED BELOW: \*\*\*\*PLEASE PRINT\*\*\*\*

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

(MINORS REQUIRE SIGNATURE OF PARENT AND/OR GUARDIAN)

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

I UNDERSTAND AND HAVE BEEN PROVIDED WITH A NOTICE OF INFORMATION PRACTICES THAT PROVIDES A MORE COMPLETE DESCRIPTION OF INFORMATION USES AND DISCLOSURES. IN ADDITION, I GIVE MY PERMISSION FOR THE PUTNAM NORTH FAMILY MEDICAL CENTER TO LEAVE A MESSAGE ON MY VOICE MAIL REGARDING UPCOMING APPOINTMENTS, ETC.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

CK IN \_\_\_\_\_ (Employee initials)