Dunkirk Family Practice PA

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Patient Information Form

Reason for Today's Visit: ____________________

Name: ____________________

Sex: □M □F □Other (Please specify): ____________

Sexual Orientation/Sexual Identity: ____________________

Which race or ethnicity best describes you?: □American Indian or Alaskan Native □Asian/Pacific Islander □Black or African American □Hispanic □White/Caucasian □Multiple ethnicity/ Other (Please specify): ____________________

Home Phone: ____________ Work Phone: __________ Cell Phone: __________

Email Address: ____________________

Home Address: ____________________ City: __________ Zip Code: ________

Patient's Social Security #: ____________________ Date of Birth: __________

Driver's License #: ____________________ State: _____ Exp. Date: ________

Marital Status: □Married □Divorced □Legally Separated □Single □Widowed

Full Time Student (Please circle): □Yes □No Name of School: ____________________

Highest Level of Education: □Less than high school degree □High school degree or equivalent (e.g. GED) □Some college but no degree □Associate degree □Bachelor degree □Graduate degree

Employment Status: □Employed, working 40 or more hours per week □Employed, working 1-39 hours per week □Not employed, looking for work □Not employed, not looking for work □Retired □Disabled, not able to work

Nearest relative not living with you: ____________________ Phone: ____________

Nearest friend not living with you: ____________________ Phone: ____________

Whom may we contact in the case of an emergency? ____________ Phone: ____________

Whom may we thank for referring you to us? ____________ Phone: ____________

Who is responsible for this bill? ____________________

Are you covered under an employer or union policy?
□Yes □No

Do you have a secondary medical insurance policy? □Yes □No

Is your spouse or other family member employed?
□Yes □No

Have you ever served in the military?
□Yes □No

Are you covered under any other health care plan?

☐Yes ☐No

Accident or Injury Information

Is this visit accident related? ☐Yes ☐No

If yes, please provide details of the accident: Date and Location: ______________________

Details of accident or injury: ______________________

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Did you consult another physician regarding any other injuries resulting from this accident?

Name of physician: ______________________

Date first seen by other physician: ______________________

Could this injury be covered under Worker's Compensation? ☐Yes ☐No

Medical Insurance

Name of Subscriber: ______________________

Relationship to Patient: ______________________

Policyholder Date of Birth: ______________ Policyholder Social Security #: ______________

Insurance Carrier Name, Address, Phone #: ______________________

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Identification card present upon encounter: ☐Yes ☐No

Eligibility date indicated on card as: ______________________

Is this plan HMO, PPO or EPO? ☐Yes ☐No

If this is for EHB; who administers the plan: ______________________

Secondary Medical Insurance

If information is same as the information above indicate with "Same as and indicate which policyholder is applicable" in the appropriate data fields.

Name of Insured: ______________________

Relationship to Patient: ______________________

Policyholder Date of Birth: ______________ Policyholder Social Security #: ______________

Insurance Carrier Name, Address, Phone #: ______________________

Identification card present upon encounter: ☐Yes ☐No

Eligibility date indicated on card as: ______________________

Is this plan HMO, PPO or EPO? ☐Yes ☐No

If this is for EHB; who administers the plan? ______________________

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential. I am aware that a copy of my insurance identification card will be made available and a copy kept in my records. I am responsible for updating this information if and when there are changes.

______________________________ ______________________________

Signature Date