AGAPÉ PRIMARY CARE

Physician: ______________________

Patient Information

______________________ ______________________ ______________________
(First Name) (Middle Name) (Last Name)

SSN:______________________ Birth Date:______________ Sex: M / F

Marital Status: (circle one) Single / Married / Divorced / Widowed / Life Partner / Separated / Unknown

Address:______________________

City:______________________ State:______________ Zip Code:______________

Home Phone:______________ Cell Phone:______________ Work Phone:______________

Ethnic Origin: (circle one) American Indian / Asian / Black / Hispanic / White / Other

Primary Language:______________ E-mail address:______________

Emergency Contact Information

Name:______________________

Relationship to Patient:______________ Phone Number:______________

Guarantor (Financially Responsible Party) **Information** **(If information is same as above please check here)** ☐

______________________ ______________________ ______________________
(First Name) (Middle Name) (Last Name)

SSN:______________________ Birth Date:______________ Sex: M / F

Marital Status: (circle one) Single / Married / Divorced / Widowed / Life Partner / Separated / Unknown

Address:______________________

City:______________________ State:______________ Zip Code:______________

Home Phone:______________ Cell Phone:______________ Work Phone:______________

Guarantor's Relationship to Patient:______________________

Guarantor (Financially Responsible Party's) **Employer Information**

Employer Name:______________________

Occupation:______________________

Address:______________________

City:______________________ State:______________ Zip Code:______________

Primary Insurance Information

Policy Holder:______________________ Sex: M / F

Policy Holder's Relationship to Patient:______________ Policy Holder's SSN:______________

Policy Holder's Birth Date:______________ Policy Holder's Phone Number:______________

Policy Holder's Address:______________________

City:______________ State:______________ Zip Code:______________

Insurance Company:______________ Effective Date: ______________

Group #:______________ Policy/Certificate ID #:______________

Insurance Company Address:______________________

Secondary Insurance Information **(If you do not have Secondary Insurance please check here)** ☐

Policy Holder:______________________ Sex: M / F

Policy Holder's Relationship to Patient:______________ Policy Holder's SSN: ______________

Policy Holder's Birth Date:______________ Policy Holder's Phone Number:______________

Policy Holder's Address:______________________

City:______________ State:______________ Zip Code:______________

Insurance Company:______________ Effective Date: ______________

Group #:______________ Policy/Certificate ID #:______________

Insurance Company Address:______________________

Release Information

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for any amount not covered by my insurance. I request that payment of authorized Medicare benefits be made to my physician. I authorize Agapé Primary Care to access my medication history.

Signature of Patient (Parental Signature if Minor)______________________ Date:______________