NEA BAPTIST CLINIC

PATIENT INFORMATION

PATIENT INFORMATION (THE PERSON SEEING THE PHYSICIAN):

DATE__________ PRIMARY CARE PHYSICIAN (PCP)__________ REFERRING PHYSICIAN__________

NAME __________ FIRST M.I. LAST SUFFIX (Jr/Sr/II etc)

MAILING ADDRESS __________ CITY __________ STATE_____ZIP_____COUNTY__________

PHYSICAL ADDRESS __________ CITY __________ STATE_____ZIP_____COUNTY__________

HOME PHONE (____) __________ CELL PHONE (____) __________ SSN __________ DATE OF BIRTH __________

EMAIL ADDRESS __________

☐ MALE ☐ FEMALE **MARITAL STATUS** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER

RACE ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ WHITE/CAUCASIAN ☐ OTHER

ETHNICITY ☐ HISPANIC/LATINO ☐ NOT HISPANIC/NOT LATINO ☐ OTHER **LANGUAGE** ☐ ENGLISH ☐ SPANISH ☐ OTHER__________

EMPLOYER __________ ☐ Full Time ☐ Part Time WORK PHONE (____) __________

EMPLOYER ADDRESS __________ CITY__________STATE__________ZIP__________

SPOUSE NAME __________ SPOUSE EMPLOYER __________

PHARMACY__________ PHARMACY PHONE __________

Is the patient a student? Y / N **Fulltime? Y / N**

Which method of communication is preferred? ☐ No contact ☐ Mail ☐ Phone ☐ Email ☐ MyChart

How did you hear about NEA Baptist Clinic? ___Billboard ___Employee ___Friend/Family ___Newspaper ___Physician Referred ___Radio ___TV ___Website ___Yellow Pages ___Other

EMERGENCY CONTACT

NAME __________ FIRST M.I. LAST

ADDRESS __________ CITY __________ STATE_____ZIP_____

HOME PHONE (____) __________ CELL PHONE (____) __________ RELATIONSHIP TO PATIENT __________

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR THE BILL. IF OVER 18 SHOULD BE PATIENT):

GUARANTOR NAME __________ FIRST M.I LAST DOB__________

MAILING ADDRESS __________ (STREET, ROUTE) CITY __________ STATE_____ZIP_____COUNTY__________

HOME PHONE (____) __________ CELL PHONE (____) __________ SSN __________ RELATIONSHIP TO PATIENT__________

EMPLOYER __________ ☐ Full Time ☐ Part Time ADDRESS__________ PHONE __________

IS THIS WORKERS COMP RELATED? Y / N **Date of Injury** __________

PRIMARY INSURED (THE PERSON WHO CARRIES THE INSURANCE):

SUBSCRIBER__________ FIRST M.I. LAST

PHYSICAL ADDRESS __________ (STREET, ROUTE)

CITY __________STATE__________ZIP__________

PHONE (____) __________

SSN __________ DATE OF BIRTH__________

RELATIONSHIP TO PATIENT ☐ Spouse ☐ Parent ☐ Other__________

EMPLOYER __________

PHONE (____) __________

INSURANCE INFORMATION

PRIMARY INSURANCE (MUST HAVE COPY OF CARD):

INSURANCE NAME __________

GROUP# __________ POLICY/ ID# __________

EFFECTIVE DATE OF INSURANCE: __________

DOES PRIMARY INSURANCE REQUIRE A REFERRAL? Y / N

SECONDARY INSURED

SUBSCRIBER__________ FIRST M.I. LAST

PHYSICAL ADDRESS __________ (STREET, ROUTE)

CITY __________STATE__________ZIP__________

PHONE (____) __________

SSN __________ DATE OF BIRTH__________

RELATIONSHIP TO PATIENT ☐ Spouse ☐ Parent ☐ Other__________

EMPLOYER __________

PHONE (____) __________

INSURANCE INFORMATION

SECONDARY INSURANCE (MUST HAVE COPY OF CARD):

INSURANCE NAME __________

GROUP# __________ POLICY/ ID# __________

EFFECTIVE DATE OF INSURANCE: __________

DOES SECONDARY INSURANCE REQUIRE A REFERRAL? Y / N

Signature__________ Date__________

OFFICE USE ONLY - SCAN DOCUMENT UNDER Amb_Registration Forms

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