Family Health Center of Melissa *Patient Demographics*

Phone Numbers: #1 _____ #2 _____ #3 _____
H-HOME, **W**-WORK, **C**-CELL **H**-HOME, **W**-WORK, **C**-CELL **H**-HOME, **W**-WORK, **C**-CELL

Name _____ DOB _____ SSN _____

Address _____ City _____ State ____ Zip _____

Email Address _____
(Addresses are collected for purposes of patient survey and will never be given to vendors or used for spam)

Marital Status: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____ Sex: Female _____ Male ____

Employment Status: Employed _____ Unemployed _____ Self Employed _____ Retired _____ F/T Student _____ P/T Student _____

Race: Native American ☐ Asian ☐ Pacific Islander ☐ Black ☐ White ☐ Refused to Provide ☐

Ethnicity: Hispanic ☐ Non Hispanic ☐ Refuse to Provide ☐ Preferred Language: _____

Employer _____ Occupation _____

Whom may we thank for referring you? _____ _____

In case of an emergency who should be notified? _____ Phone # _____

Responsible Party for Minors

Name _____ DOB _____ SSN _____

Address _____ City _____ State _____ Zip _____

Primary Contact Number _____ Secondary Contact Number _____

Relationship to Patient _____Other Authorized Parents_____

Primary Insurance Information

Insured Party_____ DOB _____ SSN _____

Relationship to Patient _____ Employer _____

Insurance Company _____ Address _____

Member ID # _____ Group # _____ Phone # _____

Secondary Insurance Information

Insured Party_____ DOB _____ SSN _____

Relationship to Patient _____ Employer _____

Insurance Company _____ Address _____

Member ID # _____ Group # _____ Phone # _____

Assignment of Benefits and Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made to **Family Health Center of Melissa** and any assisting physicians, for the services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date _____ Signature _____