

WELCOME TO BATISH FAMILY MEDICINE

Please help us to serve you by taking a few minutes to provide the following information.



PATIENT INFORMATION

Title	Last Name	First Name	MI	
Mailing Address		Apt # or Second Address Line		
City	State	Zip Code		
Birthdate	SSN	Sex	Race	Home Phone
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Student Status	<input type="checkbox"/> Part <input type="checkbox"/> Full <input type="checkbox"/> None	
Employment Status	<input type="checkbox"/> Part <input type="checkbox"/> Full <input type="checkbox"/> Retired <input type="checkbox"/> None	Employer or School Name		
Employer Address		Business or Cell Phone		
City	State	Zip Code		

EMERGENCY CONTACT INFORMATION

Emergency Contact Name	Relationship to Patient	Contact Phone
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FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Title	Last Name	First Name	MI	
Mailing Address		Apt # or Second Address Line		
City	State	Zip Code		
Birthdate	SSN	Sex	Race	Home Phone
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Employment Status	<input type="checkbox"/> Part <input type="checkbox"/> Full <input type="checkbox"/> Retired <input type="checkbox"/> None	Employer or School Name		
Employer Address		Business or Cell Phone		
City	State	Zip Code		

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I am eligible to receive benefits with the insurance information I have provided and assign my benefits, otherwise payable to me, to my provider for services rendered at Batish Family Medicine. I understand that I am financially responsible for my copay, charges not paid by my insurance (including pre-existing conditions) and for non-covered services for which it is determined I was ineligible to receive. I also authorize my provider to release all information necessary to secure payment of benefits.

Signature	Relationship to patient	Date
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Please give the receptionist your insurance card at each visit in order to update any changes to your account. All copays, deductibles and coinsurances are due at the time of each visit. Thank you.