

FAMILY PHYSICIAN'S OF SOUTHERN NEVADA

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Welcome. Thank you for selecting our health care team. To help us meet your health care needs, Please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help you.

Patient Information. (confidential)

Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Home Phone # _____ Social Security # _____
Place of Birth: City _____ State _____ Country _____
Circle appropriate: Minor Single Married Divorced Widowed Separated
If student, name of School/college _____ City _____ State _____
Patient's or parent's employer _____ Work phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or parent's name _____ Employer _____ Phone _____
Person to contact in case of emergency _____ Phone _____

Responsible party

Name of person responsible for payment _____ Relationship _____
Address _____ Phone _____
Drivers License# _____ D.O.B. _____ Bank _____
Employer _____ Work phone _____ SSN# _____

Insurance information

Name of insured _____ Relationship _____
Address _____ Phone _____
D.O.B. _____ SSN# _____ Date employed _____
Name of employer _____ Union _____ Phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance Company _____
Group# _____ Policy# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max benefits _____
DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO
Name of insured _____ Relationship _____
Name of employer _____ Union _____ Phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance Co. _____ Group# _____ Policy# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
Have you signed a DO NOT RESUSCITATE IDENTIFICATION YES NO

I authorize release of any information concerning my (my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize benefits otherwise payable to me directly to the medical provider

X _____ Date _____
Signature of patient or parent if minor