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 _____ DOB_____
FIRST M.I. LAST

MAILING ADDRESS _____ CITY _____ STATE____ZIP_____COUNTY_____
(STREET, ROUTE)

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 _____

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