Family Care Plus Clinic

Patient Information

Patient/Nombre del paciente:_____
Date/Fecha:_____ **Last (apellido)** **First (primer)** **Middle**

Address/Direccion:_____
Street (calle) **Apt#** **City (cuidad)** **State (estado)/Zip (codigo postal)**

Phone/Telefono:_____**Cellular/Celular:**_____**Work/Trabajo:**_____

E-Mail Address: _____

Marital Status: S M W D Sex/Sexo: F M Race:_____ **Age/Edad:**_____

DOB/Fecha de Nacimiento:_____ **SS#/Seguro :**_____

Employer/Nombre de Compania_____ **Occupation/Ocupacion**_____

Relationship to Insured/Relacion al asegurado: Self/Uno mismo Spouse/Esposo/Esposa Child/Hijo/Hija

Emergency Contact:_____
(contacto de emergencia) **Name** **Number**

How did you hear about us?_____

Parent Information-If patient under 18 years old

(Informacion de padres-Si paciente es menor de 18 anos)

Parent Name/Nombre de padre/madre:_____

DOB/Fecha de Nacimiento:_____**SS#/Seguro:**_____ **Sex/Sexo: F M**

Address/Direccion:_____
Street (calle) **Apt#** **City (cuidad)** **State (estado)/Zip (codigo postal)**

Phone/Telefono:_____**Cellular/Celular:**_____**Work/Trabajo:**_____

Employer/Lugar de Empleo:_____ **Occupation/Titulo:**_____

Employer Address/Direccion del Empleo:_____

Insurance Coverage

(Informacion Del Seguro)

Company Name/Nombre de Compania:_____ _____

Policy Holder/Nombre del asegurado:_____**DOB/Fecha de Nacimiento**_____

Social Security#_____**Relationship/Relacion**_____

Group #_____**Policy #/ Numero de Poliza** _____

Ins. Phone #/Tel del Aseguro:_____ _____**Secondary Company Name**

/Compania Secundaria:_____**Phone/Telefono:**_____

Policy #/ Numero de Poliza_____ **Group#**_____

Patient Agreement/ Insurance Authorization and Assignment

I request that payment of authorized insurance company benefits be made on my behalf to Family Care Plus Clinic for any services furnished me by that party who assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to the release to the Social Security Administration and Health Care Financing Administration or intermediaries or carries or any other insurance company any information needed for this or a related Medicare/Other insurance claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other insurance company assigned cases, physician or supplier agrees to accept the charge determination of the Medicare/other insurance company the full charge, and the patient is responsible only for deductible, coinsurance, and noncovered services. Coinsurance and the deductibles are based upon the charge determination of the Medicare/other insurance company.

I also give Family Care Plus Clinic permission to treat me, my minor child, or the person named on the patient information sheet.

Signature/Firma:_____ Date/Fecha:_____