Highlands Family Medicine

Patient Information

Name: _____
Address: _____
Apt#:_____**City:** _____
State: _____ **Zip:** _____
Primary Phone: _____
Second Phone:_____
Email: _____
Date of Birth: _____
Sex: ☐ **M** ☐ **F**
☐ **Other:**_____
Alternative #: _____
Social Security #: _____
Marital Status: ☐ Married ☐ Partnered
☐ Single ☐Divorced ☐ Widowed

Patient Employment/ School

☐ Employed ☐ Retired ☐ Self
☐ Unemployed ☐ Other
Employer/ school: _____
Work number: _____

Emergency Contact

Name: _____
Relationship: _____
Phone #:_____

Pharmacy

Retail Pharmacy: _____ **Mail Order Pharmacy:**_____
Pharmacy #: _____ **Mail Order #:** _____
Address or Intersection: _____

Responsible Party

☐ Self (If self, move on to "**Policyholder Information")** **Phone #:**_____
Name: _____ **Date of Birth:** _____
Address:_____
Apt #: _____**City:** _____ **State:**_____ **Zip:**_____

Policyholder Information

☐ Self (if self, move on to "**Primary Information")** **Relationship to Patient:** _____
Insured Name: _____ **Employer:** _____
Insured Date of Birth:_____ **Insured Phone #:** _____
Insured Address (If different from above): _____
_____

Primary Information

Insurance Name:_____
ID#: _____ **Group #**_____

Secondary Information (if applicable)

☐ Self (if self then move on to **"Family members in this practice"**) **Relationship to Patient:**
Insurance Name:_____**ID#:** _____
Insured Name:_____ **Group #:** _____
Employer:_____ **Phone #:** _____

Family Members in this Practice

Name:_____ **Date of Birth:**_____ **Relationship:**_____
Name:_____ **Date of Birth:**_____ **Relationship:**_____
Name:_____ **Date of Birth:**_____ **Relationship:**_____
Name:_____ **Date of Birth:**_____ **Relationship:**_____

Federally Required Question

Primary Language:
□ English
□ Spanish
□ Other: _____

Race:
□ Hispanic □Asian
□White □ Native Hawaiian
□Black/African American □ American Indian
□Other: _____

Ethnicity:
□Hispanic
□Non-Hispanic

Acknowledgment of Financial Agreement and Receipt of Privacy Practices

I hereby acknowledge the above information is true and correct. I give authorization for payment for insurance benefits to be made directly to Highlands Family Medicine (HFM) for 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's fees. I hereby authorize HFM to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original. I have been offered a copy of the Notice of Privacy Practices for my records and understand the responsibilities of HFM regarding my personal health information.

Patient/Responsible Party Signature: _____

Date: _____