



Please provide the following information for our records.  
Please bring your INSURANCE CARD and DRIVERS LICENSE to your appointment. Thank you.

Patient Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone -- Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

*As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.*

Email address: \_\_\_\_\_

How would you prefer to receive reminders from our office? (Please choose one reminder method.)

- Home Phone  Cell Phone  Work Phone  Mail  Email

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Preferred Language:  English  Spanish  Other (please list) \_\_\_\_\_

Race:  American Indian or Alaskan Native  Asian  Black or African American  White  
 Hawaiian or Pacific Islander  Other (please list) \_\_\_\_\_

Ethnic Group:  Not Hispanic or Latino  Hispanic or Latino  Other (please list) \_\_\_\_\_

Spouse/Partner Name: \_\_\_\_\_ Spouse/Partner Employer: \_\_\_\_\_

Name of Parents (if patient is dependent/minor): \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Emergency Contact Not Living With You: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Telephone: \_\_\_\_\_

Referred By: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

Is This Visit Related to Any of the Following?

- Work Injury  Yes  No  
Auto Accident  Yes  No  
Other Incident  Yes  No

Please Explain: \_\_\_\_\_

If you answered yes to any of the above, please list the date of injury: \_\_\_\_\_

My problem did not result from an accident.

**INSURANCE INFORMATION**

**BLUE CROSS BLUE SHIELD OR BLUE CARE NETWORK:**

Contract Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

**MEDICARE:**

Medicare Number: \_\_\_\_\_ Are you or your spouse employed? Yes No

What is the basis for the patient's entitlement to Medicare?

Age  Disability  Renal Disease  Other (Explain) \_\_\_\_\_

**MEDICAID:** Recipient ID Number: \_\_\_\_\_

**OTHER INSURANCE:** (Insurance Company) \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Policy/Claim Numbers: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Employer of Subscriber (if different from above): \_\_\_\_\_

Address of Employer (if different from above): \_\_\_\_\_

Claim Adjuster Name (if applicable): \_\_\_\_\_ Telephone: \_\_\_\_\_

***I authorize the release of any medical information necessary to process my insurance claim.  
I authorize payment of medical benefits to Centis Health for services rendered when they request  
that payment be made directly to them.***

\_\_\_\_\_  
Signature (Patient, Responsible Party)

\_\_\_\_\_  
Date

***I understand that I am ultimately responsible for payment of services that are rendered to me.  
I understand that Centis Health will bill my insurance company, but that I am responsible  
for any balance that my insurance does not pay as well as any copayments and/or deductibles.***

\_\_\_\_\_  
Signature (Patient, Responsible Party)

\_\_\_\_\_  
Date