Welcome to our Office...

Patient Information Sheet

Adjuva primary care

Attention **: Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.**

First Name: _____ **Last Name**: _____ **Middle Initial:** _____

Date of Birth: (MM/DD/YYYY) _____ / _____ / _____ **Gender at birth:** ☐Male ☐Female **Race:** _____ **Ethnicity:** _____ **Marital Status:** ☐ Single ☐ Married ☐ Widowed Divorced

Address: _____ **Apt.#:** _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____ **Work Phone:** (_____) _____ **Cell Phone:** (_____) _____

Emergency Contact: _____ **Emergency Telephone#:** (_____) _____

Email: _____

Specialist: _____ **Ref Dr's Add / City / State / Zip** _____ **Phone #** _____

Primary Care Physician: _____ **PCP Add / City / State / Zip** _____ **Phone #** _____

Primary Insurance Company Information:

Policy Holder First Name: _____

Policy Holder Last Name: _____

Policy Holders SS# _____-_____-_____ **Policy Holders Date of Birth:** _____ / _____ / _____

Gender: ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐ **Same as patient**

City: _____ **State:** _____ **Zip:** _____

Insurance Name: _____

Policy ID: _____ **Group #:** _____

Claim Submission Address: _____

Effective Date: _____ / _____ / _____

Do you have a Co-pay? ☐ No ☐ Yes, Amt $_____

Referral Required: ☐ **Yes** ☐ **No**

Secondary Insurance Company Information:

Policy First Name: _____

Policy Holder Last Name: _____

Policy Holders SS# _____-_____-_____ **Policy Holders Date of Birth:** _____ / _____ / _____

Gender: ☐ Male ☐ Female **Relationship to Policy Holder:** ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐ **Same as patient**

City: _____ **State:** _____ **Zip:** _____

Insurance Name: _____

Policy ID: _____ **Group #:** _____

Claim Submission Address: _____

Effective Date: _____ / _____ / _____

Do you have a Co-pay? ☐ No ☐ Yes, Amt $_____

Referral Required: ☐ **Yes** ☐ **No**

Responsible Party Information – *Please complete if the responsible for payment is not the Patient or the Policy Holder.*

Responsible Party's Name (Last / First): _____ **Relationship to Responsible Party:** ☐Self ☐Spouse

Responsible Party's Address / City / State / Zip: _____

By signing below, I acknowledge and agree to abide by this policy. I also acknowledge that I have been given the opportunity to review the Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy Practices and I agree to comply with all of its terms.

Today's Date:_____ Patient's Signature:_____