PT ID#

Welcome to North Hills Family Medicine

Please Print **Date:** _______________

Patient Demographics:

Last Name	First Name	Middle Initial

SS# ___________________________________ **Birth Date**: _____________________ Full Time Student? ❑ Yes ❑No

Street Address	City	State	Zip Code

Primary Phone _________________________ ❑Mobile? **Secondary Phone** ___________________________ ❑Mobile?

E-Mail: __________________________________ **Sex** ❑ M ❑F Marital Status ❑Single ❑Married ❑Divorced

Your e-mail and primary phone will be used to remind you of appointments and to keep you update-to-date on any news from the office. You may opt out of this service at any time.

Are any family members patients of North Hills Family Medicine & Pediatrics? ❑ Yes ❑No

Family Member/Patient's Name: _______________________________________

If so, who is their primary care physician? Dr. Geralde Dr. Naron Dr. Earp

Insurance Information:

Insurance Company ___________________________________ **Subscriber's Name** ____

Policy/ID/Member # __________________________________ **Subscriber's Date of Birth** ___________________________________

Group # ____ **Subscriber's SSN** ____

Secondary Insurance (if applicable**)** _______________________ **Subscriber's Name** ____

Policy/ID/Member # __________________________________ **Group #** ____

Who is responsible for this account, *if* other than the patient? _______________________________ Relationship ____________________________

Emergency Contact:

Name ___________________________________ **Relationship** _____________________________ **Phone #** ________________________________

Who may we share information regarding your ❑ Medical Information ❑ Billing/Payment Information?

Name: ______________________________________ Relationship: _______________________________

Name: ______________________________________ Relationship: _______________________________

How were you referred to our practice?

❑Friend/Relative Name:____________________ ❑ Yellow Pages ❑ Mail

❑Physician, if so, name: ___________________ ❑ Newspaper ❑Hospital Referral ❑ Other: ______________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with insurer.) I authorize any holder of medical or other information about me to release to the Social Security Administration and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I have received notice of this organization's privacy policies.

Signature: ____ **Date: ____________________________**