FAMILY PRACTICE CENTRE OF LIVONIA & CANTON, P.C.
PATIENT INFORMATION

Thank you for choosing our office. To help serve you properly, please complete this form in its entirety. If you have any questions or need assistance, please ask us – we will be happy to help.

PERSONAL INFORMATION

Last Name _____ First _____ Middle _____

Sex: ❑ Male ❑ Female Date of Birth _____ SS # _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Legally Separated Maiden / Other Name _____

Address: _____ Apt / Lot # _____

City _____ State _____ Zip Code _____

Home Phone # (_____) _____ Cell Phone # (_____) _____

Pager Phone # (_____) _____ Email Address: _____

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Not Employed ❑ Self ❑ Retired

Employer Name: _____ Work Phone # (_____) _____

Employer Address: _____

Student Status: ❑ Not a Student ❑ Full-Time ❑ Part-Time Name of School _____

If patient is a Minor, Give:

Father's Name: _____ Phone (_____) _____

Mother's Name: _____ Phone (_____) _____

Guardian's Name: _____ Phone (_____) _____

In case of a medical emergency, if the patient is of school age 15+, is it all right to treat in my absence.

× _____ _____
Parent or guardian signature Date

ALLERGIES TO MEDICINE / EMERGENCY CONTACT INFO

Do you have any allergies to Medicine ? ❑ No Known Allergies ❑ Yes, please List: _____

_____

In case of emergency, notify _____ Relationship _____

Home Phone (_____) _____ Other (_____) _____

RESPONSIBLE PARTY - Who is responsible for this account ?

Last Name _____ First _____ Middle _____

Sex: ❑ Male ❑ Female Date of Birth _____ SS # _____ Relation: _____

Is this person currently a patient at our office? ❑ Yes ❑ No Driver's License # _____

Address: _____ Apt / Lot # _____

City _____ State _____ Zip Code _____

Home Phone # (_____) _____ Cell Phone # (_____) _____

HOW DID YOU HEAR ABOUT OUR PHYSICIANS / OFFICE ? (Please Circle)

Phone Book Website Hospital Insurance Co. Family or Friend Other _____

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MEDICAL INSURANCE INFORMATION

Do you have prescription drug coverage? ❑ Yes ❑ No

MEDICARE PART B COVERAGE

Do you have Medicare Part B coverage? ❑ No ❑ Yes If Yes, is the Medicare coverage ❑ Primary ❑ Secondary Effective Date _____

Name on Card _____ Medicare Claim # _____

If your Medicare Part B coverage is Secondary, is it because: ❑ Still working ❑ Spouse is working ❑ on Disability ❑ Other _____

INSURANCE INFORMATION – Provide card(s) to the receptionist, we need a copy of the front and back of the card(s)

Name of Insurance _____ Is this coverage: ❑ Primary ❑ Secondary ❑ Third

Claims Address: _____ Phone # (_____) _____

Contract # _____ Group # _____ Office Visit Copay _____

Subscriber's Name: _____ Subscriber's DOB _____

Subscriber's Sex ❑ Male ❑ Female Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Dependent ❑ Other _____

Effective Date _____ Subscriber's Employer: _____

What type of Policy is this? ❑ Employer Group Plan ❑ Individual ❑ HMO ❑ Supplemental ❑ Medicaid ❑ Auto ❑ Workers Comp ❑ Other _____

Name of Insurance _____ Is this coverage: ❑ Primary ❑ Secondary ❑ Third

Claims Address: _____ Phone # (_____) _____

Contract # _____ Group # _____ Office Visit Copay _____

Subscriber's Name: _____ Subscriber's DOB _____

Subscriber's Sex ❑ Male ❑ Female Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Dependent ❑ Other _____

Effective Date _____ Subscriber's Employer: _____

What type of Policy is this? ❑ Employer Group Plan ❑ Individual ❑ HMO ❑ Supplemental ❑ Medicaid ❑ Auto ❑ Workers Comp ❑ Other _____

Authorization

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I authorize and request my insurance company to pay directly to Family Practice Centre of Livonia & Canton, P.C. insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If payment is sent directly to me, I will promptly submit the same to Family Practice Centre of Livonia & Canton, P.C.

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I understand any information provided by myself or acquired in the course of my or my dependents examination or treatment may be used to obtain payment for those services rendered. I authorize Family Practice Centre of Livonia & Canton, P.C. to use and/or release this information, when necessary, to obtain payment of any outstanding balance.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Print Name of Patient or Responsible Party Description of Responsible Party's Authority