PATIENT INFORMATION

Patient Name _____ SS# _____
Date of Birth _____ Sex _____
Address _____ City _____ Zip _____
Home Phone ( ) _____ Cell Phone ( ) _____ Other ( ) _____
E-mail _____

INTERPRETER NEEDED YES___NO___ IF SO WHAT LANGUAGE?_____
Pharmacy Preference (Name and Address) _____
Who should we thank for referring you to us? _____

Employer _____ Phone ( ) _____
Address _____ City _____ Zip _____

Responsible party/Guardian
Name _____ Relationship _____ Sex _____
Address _____ City _____ Zip _____
Phone ( ) _____ Date of birth _____ SS# _____

Primary Insurance carrier _____
Policy holder's name _____ Date of Birth _____
Employer _____ Employer's phone ( ) _____
Group # _____ Policy or ID# _____
Insurance company address _____
City _____ State _____ Zip _____

Secondary Insurance carrier _____
Policy holder's name _____ Date of Birth _____
Employer _____ Employer's phone ( )_____
Group # _____ Policy or ID# _____
Insurance company address _____
City _____ State _____ Zip _____

Emergency Contact (somebody who doesn't live with you)
Name _____ Relationship _____
Address _____ City _____ Zip _____
Phone ( ) _____

You have to provide copies of your current Insurance card(s) & Drivers License photo ID. We reserve the right to refuse treatment if these items are not provided; we also reserve the right to refuse treatment to those persons who use vulgarity of threats to staff, physicians and/or other patients.

AUTHORIZATION TO PAY BENEFITS TO FACILITY: I hereby authorize payment directly to Best Care Family Health Center. Not to exceed the reasonable and customary charge for those services. I understand the provider's charge may exceed private insurance carrier payment and if greater than such payment I will be held responsible for that amount.

Signature _____ Date _____

BESTCARE™
Family Health Center
Exceptional Medical Care for Families