Welcome to Homer Medical Center/ SPH

New Patient Information

Patient:

Full Legal Name:______________________________ **Nick Name:**________________

Date of Birth: ______________________ **Social Security #:**______________________

Physical Address:____

Mailing Address:____

Home Phone: ____-____-_____ **Cell Phone:** ____-____-_____ **Work Phone:** ____-____-_____

Employer:_________________________ **Occupation:** __________________________

Employment Status: Full time Part Time Unemployed Disabled Other

Race: White Black Asian Native American/Alaska Native Other

Ethnicity: Hispanic or Non-Hispanic **Smoker:** Current Former Never

Marital Status: Single Married Divorced Separated Widowed

Birth State: _____ **Language:**__________ **Religious Preference:** ____________________

Advance Directive: Yes No Unsure

Names of other **immediate** family members seen here:

____

IF CHILD:

Parent(s) Name :

Father: ___________________________ **DOB:**__________ **SSN**__________________

Mother: ___________________________ **DOB:**__________ **SSN**__________________

Name of parent the child resides with: ____

FINANCIALLY RESPONSIBLE INFORMATION

Name: ______________________________ **DOB:**_____________ **SSN**__________________

Mailing Address:____

Insurance:

Name of *Primary* Insurance: ____

Insurance ID # ______________________________ **Group #** __________________________

Policy Holder's Name:______________________________ **DOB:** _______________________

SS# _____-_____-______ **Patients relationship to policy holder**________________________

Policy Holder's Employer: ____

Employment Status: Full time Part Time Unemployed Disabled Other

Name of *Secondary* Insurance:____

Insurance ID # ______________________________ **Group #** __________________________

Policy Holder's Name:______________________________ **DOB:**________________________

SS# _____-_____-______ **Patients relationship to policy holder**________________________

Policy Holder's Employer: ____

Employment Status: Full time Part Time Unemployed Disabled Other

In Case of Emergency

Name of local friend or relative: __________________________**Phone #**________________

Contact's DOB_____________ **Relationship to patient:** Friend Spouse Parent Child Other

Address: ____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance I also authorize Homer Medical Center or insurance company to release any information required to process my claims.

Patient (or Guardian) Signature ________________________________ Date _______________