Welcome to Homer Medical Center/SPH

New Patient Information

PATIENT:

Full Legal Name: _____

Maiden Name/Formerly Known As: _____

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

Please circle: Male Female

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: _____