PELICANPRIMARYCARE
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PATIENT INFORMATION

Thank you for choosing **PELICAN PRIMARY CARE**. In order to properly serve you, we need the following information.

PATIENT INFORMATION

Name: (Last, First, MI) _____ Email: _____

Address: (Street) _____ (City, St, Zip) _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Social Sec#: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African Amer. ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Hispanic/Latino ☐ Other ☐ Decline

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Place of Employment: _____ Occupation: _____

Employer's Address: _____

Extended Information: (Choose One) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse or Parent: (Name) _____ (Relationship) _____ (Phone #) _____

Spouse/Parent's Employer: (Name) _____ (Work Phone #) _____

Emergency Contact: (Name) _____ (Relationship) _____ (Phone #) _____

IF SEASONAL RESIDENT: 2nd Address _____

DATES AT 2ND ADDRESS: From _____ **To** _____

Guarantor/Responsible Party: (Person Responsible for Payment of Your Service if different from Patient)

Name: _____

Date of Birth: _____ Relationship to Patient: _____

Address (if different from Patient): _____

INSURANCE INFORMATION

Name of Insured: _____ Date of Birth: _____ SS# _____

Insurance Co: _____ Policy #: _____ Group #: _____

Choose One: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ No ☐ Yes If Yes, please complete the following:

Insurance Co: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____ ☐ Self ☐ Spouse ☐ Parent ☐ Other:

PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services.

I give my permission to leave phone messages regarding my medical care/appointment confirmation: ☐ Yes ☐ No

☐ Check here to authorize us to contact you by email.

Signed (Patient or Guardian) _____ **Date** _____

All bills are ultimately the responsibility of the patient. We will file insurance claims as noted, however, if your insurance has not paid in 60 days, the bill is due and payment by you is expected immediately.