



PT ID# _____

Welcome to Our Practice

Please Print

Date _____

Patient _____
 Last Name First Name Initial
 SS# _____ Birth Date _____ Full Time Student? _____
 Street Address _____ City _____ State _____ Zip _____
 Home Phone _____ Sex M F Single Married Divorced Age _____
 Cell Phone _____ Are you interested in accessing your medical records online? _____

Are any family members patients of North Hills Family Medicine? Yes No
 If so, who is their primary care physician? Dr. Geralde Dr. Naron Dr. Earp

Do you have Medical Insurance? _____ Subscribers Name _____
 Name of Insurance Company _____ Subscribers Date of Birth _____ ID # _____
 # _____ Group # _____ Subscribers Social Security# _____

Name of Secondary Insurance Company (if any) _____
 ID # _____ Group # _____ Subscribers Name _____

Spouse's name _____ Spouse's Social Security # _____
 Spouse Employed By _____ Business Address _____
 Occupation _____ Business Phone _____

Emergency Contact: Name _____ Relationship _____
 Phone: _____ Cell: _____
 Who is responsible for this account, if other than yourself? _____ Relationship to Patient: _____

Whom may we share information regarding your _____ medical information _____ billing/payment information?
 Name: _____ Relationship: _____

How were you referred to our practice? Friend/Relative, if so, name: _____ Yellow Pages Mail
 Physician, if so, name: _____ Newspaper Hospital referral Other? _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with insurer). I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I have received notice of this organization's privacy policies.

Signature: _____ Date: _____