FOUNTAIN HEALTH

PATIENT INFORMATION – Please Print Clearly

Last Name:_____First:_____Middle:_____

Birth Date: _____D_____ M _____Y Gender: Female ___ Male ___

Mailing Address: _____

_____ Postal Code: _____

Email: _____

We will communicate to this email for appointments & documents

Please circle preferred contact phone number below.

Home: _____Work:_____ Cell: _____

Spouse Name: _____Spouse Phone for emergency _____

Emergency Contact (other than spouse): _____ Phone Number: _____

Who may we discuss your medical condition with? _____ Relationship: _____

INSURANCE INFORMATION

PLEASE CIRCLE INSURANCE COMPANY:

Insurance Co. ARGUS BF&M COLONIAL GEHI HIP FUTURE CARE CASH OTHER _____

Policy Group Number: _____**Certificate Number**: _____ **Effective date**:_____

Name of Policyholder: Surname: _____First Name: _____
(IF NAME IS DIFFERENT FROM ABOVE)

Insured's Date of Birth: _____D_____M_____Y_**Relationship to Insured**: (**Parent / Spouse**)
(IF NAME IS DIFFERENT FROM ABOVE)

Employer:_____

Referring Physician: _____

Family Doctor: _____

Preferred Pharmacy: _____

Preferred Laboratory: _____

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 FOUNTAIN HEALTH or insurance company to release any information required to process my claim.

Patient or Responsible Party Signature: _____ Date: _____D_____M_____Y