Harrison Health*Partners* **Internal Medicine & Adult Primary Care**

PATIENT'S NAME:_____ BIRTHDATE:_____
LAST FIRST MI

ADDRESS:_____ _____ _____ _____
MAILING ADDRESS CITY STATE ZIP

PHONE#: (_____)_____ PATIENT'S SS#:_____

WORK PHONE#:(_____)_____ EMPLOYER:_____

MARITAL STATUS:_____ SPOUSE'S NAME:_____DOB:_____

SPOUSE'S EMPLOYER:_____ WORK PHONE#(_____)_____

IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THE FOLLOWING:

NAME OF RESPONSIBLE PARTY:_____ DOB:_____

RELATIONSHIP TO PATIENT:_____ PHONE#:(_____)_____

ADDRESS:_____

EMPLOYER:_____ WORK PHONE#:(_____)_____

REFERRAL INFORMATION:

REFERRED BY:_____ PRIMARY CARE PHYSICIAN:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____ SECONDARY INSURANCE:_____

SUBSCRIBER:_____ SUBSCRIBER:_____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD

SUBSCRIBER'S DATE OF BIRTH:_____ SUBSCRIBER'S DATE OF BIRTH:_____

ID#:_____ ID#:_____

GROUP#:_____ GROUP#:_____

COMPANY NAME:_____ COMPANY NAME:_____

IF YOU HAVE HEALTH INSURANCE OF ANY KIND, WE WILL DO EVERYTHING WE CAN TO HELP YOU OBTAIN YOUR PAYMENT FROM YOUR INSURANCE COMPANY. HOWEVER, THE BASIC RESPONSIBILITY FOR PAYMENT IS YOURS.

THANK YOU FOR CHOOSING OUR OFFICE!