Date: PCP (Primary Care Physician):_____

D.O.B._____

SSN#:_____ SEX: ☐ Female ☐ Male Marital Status: ☐ S ☐ M ☐ SEP ☐ D ☐ W

Home address:_____

City/State/Zip Code:_____

Home Phone #:_____ Work Phone #:_____

Daytime/Call Phone #_____ EXT #:_____

Employer Name:_____ Occupation:_____

Employer Address:_____ City/State/Zip Code:_____

ETHNICITY: (Select one)	RACE: (Select one)
☐ Hispanic/Latin/Spanish Origin	☐ American Indian/Alaskan Native ☐ Hispanic/Latino
☐ NOT Hispanic/Latin/Spanish Origin	☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Decline	☐ Black/African American ☐ White ☐ Decline

Preferred Method of Communication: (Select one)

☐ Telephone ☐ Mail ☐ Decline

PERSON RESPONSIBLE FOR PATIENT'S FINANCIAL OBLIGATION, IF SELF, INDICATE SELF

Name:_____

Relationship:_____ SS#:_____ DOB:_____

Home Phone:_____ Work Phone #:_____ Ext:_____

Daytime/Cell Phone #:_____ Ext:_____

Home Address (If different from Patient's address):_____

City/State/Zip Code:_____

Employer Name:_____ City/State/Zip Code:_____

EMERGENCY CONTACT

Primary Contact Name:_____ Relationship:_____

Home Phone #:_____ Work Phone #:_____ Ext:_____

Daytime/Cell Phone #:_____ Ext:_____

Home Address:_____ City/State/Zip Code:_____

Secondary Contact Name:_____ Relationship:_____

Home Phone #:_____ Work Phone #:_____ Ext:_____

Daytime/Cell Phone #:_____ Ext:_____

Home Address:_____ City/State/Zip Code:_____

PATIENT INSURANCE INFORMATION Do You Have Health Insurance? YES ☐ NO ☐

Primary Insurance	Secondary Insurance
Insurance Co:_____	Insurance Co:_____
Insurance Phone #:_____	Insurance Phone #:_____
Subscriber:_____	Subscriber:_____
Subscriber's Employer Name:_____	Subscriber's Employer Name:_____
Subscriber's Date of Birth:_____	Subscriber's Date of Birth:_____
Subscriber's SSN #:_____	Subscriber's SSN #:_____
Policy #_____	Policy #:_____
Group #_____	Group #:_____
Effective Date:_____	Effective Date:_____

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance company to make payments to Providence Mission Heritage Medical Group, benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this Assignment. This Authorization will remain in effect until rescinded by myself in writing. A photocopy of this Assignment may be honored.

Patient's Signature:_____ Date:_____

Witness' Signature:_____ Date:_____

Providence
Mission Heritage
Medical Group

INFORMATION SHEET

MRN
Patient Name:
Date of Birth: