Family Practice, PLLC 5130 Corporate Center CT SE, Lacey, WA 98503 Phone: 360-413-8600/Fax: 360-413-8822

ADULT PATIENT INFORMATION FORM

Last Name____________________ First name ________________ MI____ Male___ Female___

Date of birth____/____/____ Social Security#____ - ___ - ____ Driver's license # ____________

Home phone ____________ Cell phone ____________ Email____________

Physical address________________________ Apt#______

City ____________ State ____________ Zip code ________ - _____

Mailing address if different from above ____________________ Apt#______

City ____________ State ____________ Zip code ________ - _____

Race: Asian ___ Native Hawaiian ___ Black or African American___ White___ Hispanic___ Other race________

Ethnicity: Hispanic ____ Not Hispanic ____ Language: English___ Spanish___ Other________

Employer____________________ Work phone (____)________

Occupation ____________________ Primary care doctor ____________

Immediate family members____________________ Referred by____________

SPOUSE/PARTNER INFORMATION

Name ____________________ Date of birth ____/____/____

Social Security # ____ - ___ - ____ Driver's license # ____________ Occupation____________

Employer ____________________ Work phone (____)________

Is spouse/partner a patient in this office? Yes____ No____ If yes, which doctor____________

RESPONSIBLE PARTY INFORMATION

Phone (____)________

Name ____________________ Date of birth ____/____/____

Mailing address ________________________

Social Security # ____ - ___ - ____ Driver's license # ____________ Occupation____________

Employer ____________________ Work phone (____)________

EMERGENCY CONTACT (please provide name of friend or relative not living with you that can be reached in case of an emergency)

Name ____________________ Phone (____)________

Relationship to patient ____________________ Cell phone (____)________

Address ________________________

INSURANCE INFORMATION (*we need current copy of card on file please)*

Insurance Co Name ____________________ Name of insured ____________

Subscriber/member # ____________________ Group # ____________ Co pay $ ______

Insured's address ____________________ Phone # (____)________

(if different than above information)

Secondary insurance ____________________ Policy # ____________

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS/CONTRACT

I hereby authorize Pioneer Family Practice to release to my primary and secondary insurance company any medical information necessary to process my insurance claim(s). My signature also authorizes any insurance benefits to be paid on my behalf to the providers at PFP. I hereby agree to full responsibility for all expenses incurred by myself or minor child. I understand that are billing fee/finance charge complying with Washington State Law may be applied to any overdue balance. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

MEDICARE PATIENTS ONLY: I understand my provider agrees to accept the Medicare allowed charge as the full charge and I am only responsible for the deductible, co-insurance and non-covered services.

Signature ____________________ Date ____/____/____

(Legal guardian must sign if patient is a minor)

Relationship to patient ____________________