COVENANT MEDICAL GROUP INFORMATION SHEET

EMRN: _____

PLEASE PRINT CLEARLY DATE: _____

PATIENT NAME _____ AKA (also known as): _____

SSN: _____ D.O.B.: _____ SEX: Female ☐ Male ☐

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

HOME ADDRESS: _____

CITY/STATE _____ ZIP: _____

PRIMARY PHONE #: _____ CELL PHONE #: _____

WORK PHONE #: _____ EXT: _____

EMPLOYMENT STATUS: _____ EMPLOYER NAME: _____

EMAIL ADDRESS: _____

ETHNICITY: (Select one)

☐ Hispanic/Latin/Spanish Origin
☐ NOT Hispanic/Latin/Spanish Origin
☐ Decline

RACE: (Select one)

☐ American Indian/Alaskan Native ☐ Hispanic/Latino
☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Decline

PREFERRED LANGUAGE: (Select one)

☐ English ☐ Spanish ☐ Other: _____

PCP (Primary Care Physician): _____

PERSON RESPONSIBLE FOR PATIENT'S FINANCIAL OBLIGATION

IF SELF, CHECK BOX BELOW AND CONTINUE TO EMERGENCY CONTACT SECTION

☐ Self

NAME: _____

RELATIONSHIP: _____ SS#: _____ DOB: _____

HOME PHONE: _____ WORK PHONE #: _____ EXT: _____

CELL PHONE #: _____

HOME ADDRESS (If different from Patient's address): _____

CITY/STATE/ZIP CODE: _____

EMPLOYER NAME: _____ CITY/STATE/ZIP CODE: _____

IN CASE OF EMERGENCY - NAME OF RELATIVE NOT LIVING WITH YOU (Local)

PLEASE LIST AT LEAST ONE CONTACT

PRIMARY CONTACT NAME: _____ RELATIONSHIP: _____

PRIMARY PHONE #: _____ WORK PHONE #: _____ EXT: _____

CELL PHONE #: _____

HOME ADDRESS: _____ CITY/STATE/ZIP CODE: _____

SECONDARY CONTACT NAME: _____ RELATIONSHIP: _____

PRIMARY PHONE #: _____ WORK PHONE #: _____ EXT: _____

CELL PHONE #: _____

HOME ADDRESS: _____ CITY/STATE/ZIP CODE: _____

PATIENT INSURANCE INFORMATION DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐

PRIMARY INSURANCE

INSURANCE CO: _____
INSURANCE PHONE #: _____
SUBSCRIBER: _____
POLICY #: _____
GROUP#: _____
EFFECTIVE DATE: _____
SUBSCRIBER'S EMPLOYER NAME: _____
SUBSCRIBER'S DATE OF BIRTH: _____
SUBSCRIBER'S SSN #: _____

SECONDARY INSURANCE

INSURANCE CO: _____
INSURANCE PHONE #: _____
SUBSCRIBER: _____
POLICY #: _____
GROUP #: _____
EFFECTIVE DATE: _____
SUBSCRIBER'S EMPLOYER NAME: _____
SUBSCRIBER'S DATE OF BIRTH: _____
SUBSCRIBER'S SSN #: _____