PROVIDENCE
Medical Group

(CLINIC USE ONLY)

PCP	ACCOUNT #	
	☐ NEW ☐ UPDATE	TODAY'S DATE

PATIENT INFORMATION

PATIENT'S NAME LAST FIRST MIDDLE	BIRTHDATE	SEX ☐ MALE ☐ FEMALE	HOME PHONE
PATIENT'S ADDRESS CITY STATE ZIP			
PATIENT'S SOCIAL SECURITY NUMBER	HAVE YOU EVER BEEN HERE BEFORE? ☐ YES ☐ NO	IF SO, WHEN AND BY WHOM?	MARITAL STATUS ☐ S ☐ M ☐ Other
PATIENT'S EMPLOYER	OCCUPATION		WORK PHONE
PATIENT'S WORK ADDRESS CITY STATE ZIP			EMPLOYED SINCE

SPOUSE / PARENT INFORMATION

☐ SPOUSE ☐ PARENT IF PATIENT A MINOR LAST FIRST MIDDLE	BIRTHDATE	SOCIAL SECURITY #
EMPLOYER	OCCUPATION	PHONE AT WORK
☐ SECOND PARENT IF PATIENT A MINOR LAST FIRST MIDDLE	BIRTHDATE	SOCIAL SECURITY #
EMPLOYER	OCCUPATION	PHONE AT WORK

EMERGENCY CONTACT

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU	RELATION TO PATIENT	WORK PHONE
ADDRESS CITY STATE ZIP		HOME PHONE

INSURANCE INFORMATION

INSURANCE COMPANY #1	POLICY HOLDER	RELATION TO PATIENT	Policy Holder's Birthdate
LIST ALL NUMBERS (ALSO HAVE CARD AVAILABLE FOR THE RECEPTIONIST TO PHOTOCOPY I.D. NUMBER GROUP NUMBER			$CO-PAY$
INSURANCE COMPANY #2	POLICY HOLDER	RELATION TO PATIENT	Policy Holder's Birthdate
LIST ALL NUMBERS (ALSO HAVE CARD AVAILABLE FOR THE RECEPTIONIST TO PHOTOCOPY) I.D. NUMBER GROUP NUMBER			$CO-PAY$

INJURY INFORMATION

PATIENTS INJURED IN A MOTOR VEHICLE OR OTHER NON-WORK INJURY PLEASE COMPLETE BELOW.

DATE OF INJURY	YOUR CHIEF COMPLAINT AS A RESULT OF INJURY	WHERE AND HOW DID ACCIDENT OCCUR
YOUR MOTOR VEHICLE INSURANCE	INSURANCE COMPANY'S ADDRESS	
ADJUSTER'S NAME IF KNOWN	ADJUSTER'S PHONE	CLAIM #

PATIENTS INJURED AT WORK MUST HAVE REPORTED INJURY TO EMPLOYER AND COMPLETE THE NEXT TWO LINES

WORKER'S COMP (INDUSTRIAL) INSURANCE CARRIER	DATE OF INJURY	EMPLOYER AT TIME OF INJURY
CARRIER'S ADDRESS CITY STATE ZIP		CLAIM #

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC.

PATIENT SIGNATURE _____ DATE _____
(PARENT IF PATIENT IS A MINOR)