Internal Medicine Associates

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PATIENT INFORMATION

Patient Information

PATIENT - Last Name	First Name	MI	Social Security #	Date of Birth

Street Address	City	State

Zip Code	Country	Home Telephone #	Work Telephone #	Ext.	Cell Phone #
		( )	( )		( )

Sex M F	Employer:	Employer Address

Language	Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Race: ❑ White ❑ African American ❑ American Indian/Alaskan ❑ Asian ❑ Hawaiian/Pacific Islander
❑ Other _____ ❑ Patient decline to answer

E-mail:	How may we contact you regarding medical information, test results, etc.? ❑ Call my home ❑ Call my work ❑ Call my cell phone ❑ Other _____

Emergency contact name and number **(Outside of your Home):**

Referring Physician

Last Name	First Name	MI	Telephone #
			( )

Street Address	City	State	Zip Code

Person Responsible for Bill (Omit if Same as Patient Information)

Last Name	First Name	MI	Social Security #	Date of Birth

Street Address	City	State

Zip Code	Country	Home Telephone #	Work Telephone #	Ext.	Cell Phone #
		( )	( )		( )

Sex M F	Employer:	Employer Address

Relationship to Patient	E-mail

Primary Insurance

Insurance Co. Name	Telephone#
	( )

Address to Mail Claim		

City	State	Zip Code

Name of Insured	

Date of Birth	Social Security #

Group #	Policy #

Secondary Insurance

Insurance Co. Name	Telephone #
	( )

Address to Mail Claim		

City	State	Zip Code

Name of Insured	

Date of Birth	Social Security #

Group #	Policy