



(Please Print)

Today's date:				Primary Care Physician:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security Number:		Home phone no.: ( )		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer: Address:			Employer phone no.: ( )		
Reason For Visit:					Date of Injury:		
Other family members seen here:							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Complete Address (if different):			Home phone no.: ( )	
Occupation:	Employer:	Employer address:			Employer phone no.: ( )		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>Please indicate primary insurance</b>		<input type="checkbox"/> Aetna	<input type="checkbox"/> Bravo	<input type="checkbox"/> CIGNA	<input type="checkbox"/> Gateway Health	<input type="checkbox"/> HealthPartners	
<input type="checkbox"/> IBC	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> United Healthcare		<input type="checkbox"/> Other (Specify)		
Subscriber's Name:		Subscriber's SSN:	Birth date: / /	Group No.:		Policy No.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:		Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Express Care - Roxborough Memorial or my insurance company to release any information required to process my claims.</p>				
<hr/> <i>Patient/Guardian signature</i>			<hr/> <i>Date</i>	