# Patient Information

SIMON Family Medicine
YOUR FAMILY'S DOCTOR

| Last Name | First Name | Middle | Suffix |
|---|---|---|---|
| | | | |

| Date of Birth | Gender<br>M F | Social Security Number<br>- - | Marital Status (circle)<br>Single Married Other |
|---|---|---|---|
| | | | |

| Mailing Address: Street (Line 1) | Street (Line2) |
|---|---|
| | |

| City | State | Zip | Employer/School Name |
|---|---|---|---|
| | | | |

| Home Phone | Cell Phone | Work Phone | Preferred Pharmacy |
|---|---|---|---|
| | | | |

| Email | Contact Preference (circle)<br>Phone Email Mail | Whom may we thank for referring us? |
|---|---|---|
| | | |

**Emergency Contact**

| First Name | Last Name | Phone Number | Relationship to Patient |
|---|---|---|---|
| | | | |

**Census Bureau Categorization**

| Race | Ethnicity | Language Preference | Barriers to Communication<br>Vision Hearing None |
|---|---|---|---|
| | | | |

**Do you have insurance coverage?** _____ **IF NOT, PAYMENT IS REQUIRED AT TIME OF SERVICE**

| **Primary Insurance Plan** | | | Primary Insurance ID No. | Group No. | Copay |
|---|---|---|---|---|---|
| Insurance Address (Line 1) | | | Insurance Plan Phone | Guarantor's Name (Last, First, Middle) | |
| Insurance Address (Line 2) | | | Guarantor's SSN<br>- - | Guarantor's Date of Birth | |
| City | State | Zip | | Patient relationship to guarantor (circle)<br>Self Spouse Child Other | |
| **Secondary Insurance Plan** | | | Secondary Insurance ID No. | Group No. | Copay |
| Insurance Address (Line 1) | | | Insurance Plan Phone | Guarantor's Name (Last, First, Middle) | |
| Insurance Address (Line 2) | | | Guarantor's SSN<br>- - | Guarantor's Date of Birth | |
| City | State | Zip | | Patient relationship to guarantor (circle)<br>Self Spouse Child Other | |

## ASSIGNMENT AND RELEASE

I, _____, the undersigned, certify that I (or my dependents) have insurance coverage with the above listed insurance carrier and or the insurance Simon Family Medicine has on my file, and I assign directly to *Dr. Simon* all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize *Simon Family Medicine* to bill my insurance company and to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance submissions. I understand that my "Private Healthcare Information" will be used according to the Office Policy and Regulations. **I understand that I am ultimately responsible for the charges incurred in this office, regardless of the type of insurance that I have**. I am also aware of the 1.5% finance charges that may be assessed on my account if over 30 days past due.

_____ _____

Patient/Responsible Party Signature Date