GOOD HEALTH ASSOCIATES

Today's Date _____ How did you hear about our office_____

PERSONAL INFORMATION:

Name: _____
FIRST MIDDLE LAST

_____
STREET ADDRESS CITY STATE/ZIP

(___)_____ (___)_____
HOME TELEPHONE CELL PHONE

_____ _____
DATE OF BIRTH SOCIAL SECURITY NUMBER

_____ (___) _____
EMPLOYER'S NAME WORK TELEPHONE NUMBER

_____ _____
SPOUSE'S NAME SPOUSE'S DATE OF BIRTH

_____ _____
SPOUSE'S EMPLOYER SPOUSE'S WORK NUMBER

Where do you prefer to receive calls? ___Home___Work___Mobile
May we leave information on your answering machine or voice mail? ___Yes ____No
Do you have an Advance Directive? ___Yes __ _No
With whom may we share health information? _____
Pharmacy name: _____ Pharmacy phone number_____

In the event of an emergency please contact:

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____

BILLING INFORMATION (Who will pay for services not covered by insurance?)

Name: _____ Relationship to patient: _____
Address:_____
Date of Birth:_____ Social Security # _____
Work Number:_____ Home Number: _____

INSURANCE INFORMATION (Please provide insurance card for us to copy)

Primary Ins Co_____ **Secondary Ins Co _____**
ID# _____ **ID#_____**
Insured's Name _____ **Insured's Name _____**
Insured's DOB _____ **Insured's DOB _____**
Relationship to Patient: __SELF__ SPOUSE __CHILD **Relationship to Patient: __SELF__ SPOUSE __CHILD**
Employer _____ **Employer _____**
Insured's SS# _____ **Insured's SS# _____**

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Good Health Associates, PLLC. I understand that my insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.

_____ _____
Patient's Signature (Parent's signature if under 18) Date