Please Check One:

Primary Provider: ☐ Dr. Tolson ☐ Dr. Turner ☐ Dr. Tartaglia ☐ Dr. Underhill ☐ Dr. Nebeker ☐ Dr. Devine

PATIENT INFORMATION

Last Name: ______________ First Name: ______________ Middle Init.: ________

Nickname: ______________ Maiden: ______________ Prefix: ________ Suffix: ________

Birthdate: _____/_____/_____ Sex: ☐ MALE ☐ FEMALE SS#: ______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ______________

Home Address: ______________ Apt #: ________

City: ______________ State: ______________ Zip: ________

Home #: ______________ Work #: ______________ EXT.: ________ Cell #: ______________

Preferred Daytime Phone: ( ) Home ( ) Cell ( ) Work OTHER: ______________

Email: ______________ Student: Y / N F/T ______ P/T ______

Employer: ______________

We are required to ask for the following information per the new insurance reporting requirements

Race: ☐ American Indian ☐ Asian ☐ African American ☐ Caucasian Other ______________

Ethnicity: ☐ Hispanic/Latino ☐ Other ______________

Preferred Language: ☐ English ☐ Spanish Other ______________

☐ I do not want to provide this information

PREFERRED PHARMACY

Name: ______________ Phone #: ______________

Location (crossroads): ______________

EMERGENCY CONTACT

Name: ______________ Relationship: ______________

Home #: ______________ Work #: ______________

FOR NEW PATIENTS - HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ Friend ☐ Internet ☐ Insurance Plan ☐ Postcard/Mailer ☐ Other ______________

FINANCIAL/INSURANCE INFORMATION

Patient Name ____ Date ____________________

PRIMARY INSURANCE

Insurance Co. Name: ____

Policy Holder's Name: ______________________ **Employer:** ______________________

Policy Holder's Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Spouse** ☐ **Other** ____________________

Policy Holder's DOB: ____________________ **SS#:** __________________ **Sex:** ☐ **MALE** ☐ **FEMALE**

Member ID #: ______________________ **Group #:** ______________________

SECONDARY INSURANCE

Insurance Co. Name: ____

Policy Holder's Name: ______________________ **Employer:** ______________________

Policy Holder's Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Spouse** ☐ **Other** ____________________

Policy Holder's DOB: ____________________ **SS#:** __________________ **Sex:** ☐ **MALE** ☐ **FEMALE**

Member ID #: ______________________ **Group #:** ______________________

COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN PATIENT

Responsible Party Name: ____________________ **DOB:** ______________ **SS#:** ______________

Address: ______________________________ **Relationship to Patient:** ____________________

City: ________________ **State:** _____ **Zip:** _______ **Employer:** ______________________

Home #: (______) ______________ **Work #:** (______) ______________ **Cell #:** (______) ______________

BENEFIT ASSIGNMENT / ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby authorize the staff of Paseo Family Physicians, (PFP) to provide such medical services, either regular or emergency, as may be determined by my physician to be in my best interest (or the best interest of my dependent if I am signing as a parent or guardian).

I authorize payment of medical benefits to PFP. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility. I hereby authorize PFP to release the necessary information regarding me to my health plan in order to complete and process my insurance claims. I understand that co-pays, deductibles and co-insurance amounts are due at the time of service. PFP may apply a $20 processing fee for all co-pays that are not paid at the time of service. Should it become necessary for my account to be forwarded to an outside agency, I understand that PFP may charge a $35 processing fee.

I hereby acknowledge that I have been presented with a copy of Paseo Family Physicians' NOTICE OF PRIVACY PRACTICES and PAYMENT POLICY. Please note, all forms and policies can be found on PFP's website at www.paseodocs.com.

Signed (Patient or Parent, if minor) ________________________________ **Date** ________________