Internal Medicine Primary Care
Patient Information

IMPC

Patient Information: ☐ Adult ☐ Child Date:_____

Last Name:_____ First Name:_____ MI:_____ DOB:_____

SSN:_____-_____-_____ DL#:_____Preferred Pharmacy/Location:_____

☐Male ☐Female ☐Married ☐Single ☐ Other_____

Race: ☐ American Indian/Native ☐ African American/Black ☐ Hawaiian/Pacific Islander
☐ Asian ☐ Caucasian/White ☐ Declined ☐ Other Race_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Mailing Address:_____

City:_____State:_____ Zip Code:_____

Phone# Home:_____ Work:_____ Cell:_____

E-Mail:_____Preferred Communication: ☐ Home ☐ Work ☐ Cell

Employer:_____
☐ Full Time ☐ Part Time Occupation_____ Phone#_____

Person Responsible for Patient Account
☐ Self ☐ Other Name:_____Relationship_____

Insurance Coverage	Primary Insurance	Secondary Insurance
Name of Insurance Company	_____	_____
Policy Holder:	_____	_____
Date of Birth:	_____	_____
Employer/Occupation:	_____	_____
Relationship to Insured:	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Self ☐ Spouse ☐ Child ☐ Other
Policy Number:	_____	_____
Group Number:	_____	_____

Individual(s) you would like to authorize release of your medical information.

Name:_____Relationship_____

Name:_____Relationship_____

In case of emergency notify:_____Phone:_____

Nearest relative or friend not living with you:_____ Phone:_____

This information is necessary for our courtesy billing to your insurance company. We can never guarantee payment by your insurance company. The insurance company's contract is with you and your employer or insurance company.

Your Signature (or Parent/Guardian):_____Date:_____