

# South Oaks Family Medicine, P. A.

Patient Name: \_\_\_\_\_  
(Please Print) Last First Middle

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell/Pgr: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Occupation: \_\_\_\_\_ Name of School: \_\_\_\_\_

Spouse/Parent Name: \_\_\_\_\_ Spouse/Parent Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Relationship: \_\_\_\_\_

## RESPONSIBLE PARTY

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Policy Holder Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Employer: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ Insurance thru Employer: Yes/No

Name of Ins. Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Address: \_\_\_\_\_

Ins. Phone #: \_\_\_\_\_ Co-pay: \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

*As a courtesy, SOFM will file an initial claim to your secondary insurance. Should the insurance co. not respond in a timely manner, the balance due will be the responsibility of the "responsible party". \_\_\_\_\_ (Initial)*

Policy Holder Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Employer: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ Insurance thru Employer: Yes/No

Name of Ins. Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Address: \_\_\_\_\_

**MEDICAL CARE:** I authorize the physicians of South Oaks Family Medicine or their designee to provide myself, or my child with reasonable and proper medical care according to today's standard.

**MEDICAL INFORMATION:** I authorize the physicians of this office to release any information they have acquired in the course of my or my child's treatment to my insurance company / companies, so that they may obtain payment for medical services rendered.

**INSURANCE AUTHORIZATION:** I hereby authorize the physicians or staff of this office to furnish information to my insurance carriers concerning myself or my child's illness and treatments.

**ASSIGNMENT OF BENEFITS:** I authorize the insurance company to pay any benefits due directly to this office, should they accept assignment of my claim. I also agree that I am financially responsible for the account, even though insurance may be pending on all or a portion of the charges. For all services rendered to minor patients, we will look to the adult accompanying the patient for payment. \_\_\_\_\_ (Initial)

**NOTICE OF PRIVACY PRACTICES:** I have reviewed this office's Notice of Privacy Practices, which explain how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_