Family Practice Associates
a professional corporation

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Telephone: (330) 832-3188

Date: _____ Home Phone _____

Patient Information

Name: _____ _____ _____ Social Sec. #: _____
Last Name First Name Initial

Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birth Date: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Whom may we thank for referring you? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance

Person Responsible for Account: _____ _____ _____
Last Name First Name Initial

Relationship to Patient: _____ Birth Date: _____ Social Sec. #: _____

Address (if different from patient) _____ Phone: _____

City: _____ State: _____ Zip: _____

Person Responsible Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____

Contract or ID #: _____ Group #: _____ Subscriber #: _____

Names of other dependents covered under this plan: _____

Additional Insurance

Is patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber Name: _____ Relation to Patient: _____ Birth Date: _____

Address (if different from patient's): _____ Phone: _____

City: _____ State: _____ Zip: _____

Subscriber Employed By: _____ Business Phone: _____

Insurance Company: _____ Social Sec. #: _____

Contract or ID #: _____ Group #: _____ Subscriber #: _____

Names of other dependents covered under this plan: _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Family Practice Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges paid or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship to patient Date