Choctaw Family Medicine & Aesthetics

Patient Information Form

PATIENT INFORMATION (Please Print Legibly)

Last Name: _____

First Name: _____ MI: _____
(Name must match your Insurance I.D. card.)
Mailing
Address:_____

City/ST/Zipcode: _____

Please indicate the number you would like CFMA to call for appointment reminders:

Home Phone :(_____) _____-_____ ◯ Leave Message

Cell Phone: (_____) _____-_____ ◯ Leave Message

Work Phone: (_____) _____-_____ext:_____

Date of Birth (mm/dd/yyyy): _____/_____/_____

Sex: Male O Female O

Marital Status: Single O Married O
Divorced O Widowed O

Social Security: _____-_____-_____ (**REQUIRED**)

Driver's License #: _____ State_____

Race: American Indian or Alaska Native O Asian O
Native Hawaiian O African American O
White O Hispanic O Other Race O

Ethnicity: Hispanic O Non-Hispanic O
Email: _____@_____
Pharmacy where you want your prescriptions sent:
Pharmacy Name: _____

Address:_____

RESPONSIBLE PARTY (Person who will take care of bill, <u>NOT your insurance company</u>.)

Self O Spouse O Parent O Other O
Name:_____

DOB:____/_____/_____ SSN:_____

Employer's Name:
_____

Address:_____

City/ST/Zip:_____
Is your address & phone number the same as patient? Yes / No
If No, Mailing address:
_____

City/State/Zip: _____

Home Phone: (_____)_____-_____

Work Phone: (_____) _____-_____

EMERGENCY CONTACT (Not living in same household.)

Name: _____

Relationship to Patient: _____

Phone: (_____)_____-_____ 2nd Phone: (____)____-_____

IF PATIENT IS A MINOR:

Mother's Name: _____

DOB: ____/_____/_____ SSN:_____-____-_____

Employer Name: _____

Address: _____

Work Phone: (_____) _____-_____ext:_____

Father's Name: _____

DOB: ____/_____/_____ SSN: _____-____-_____

Employer Name: _____

Address: _____

Work Phone: (_____) _____-_____ext:_____

INSURANCE INFORMATION (Please provide correct information or you will be held liable for claims not paid because of incorrect or missing information.)

Primary Insurance: _____
Policyholder
Name: _____

DOB:____/____/_____ SSN:_____-_____-_____

Group ID #:_____ Individual ID #:_____

Secondary Insurance:_____
Policyholder
Name:_____

DOB: ____/____/_____ SSN: _____-_____-_____

Group ID #:_____ Individual ID #:_____

ADVANCE DIRECTIVE (Adults age 20 or older; circle one & sign or initial by the selection of your choice.)

I **do** or **do not** want to be placed on life support.

Signature: _____

I **decline** to make this decision at this time. Initials _____

I understand and agree that (<u>regardless of my insurance status</u>) I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have answered all applicable questions.
I certify that this information is true and correct to the best of my knowledge and I understand it is my responsibility to notify CFMA of any changes to my information or status.

_____ _____
Patient/Guardian Signature Date
_____ CFMA Witness _____Date

INFORMATION IS REQUIRED IN ALL BLANKS……IF NOT APPLICABLE PUT *N/A*….INCOMPLETE FORMS WILL NOT BE ACCEPTED. 2016