Patient Information

Last Name:	MI:	First Name:	
Birthdate: / /	Sex: **M** / **F**	Marital Status: **S** / **M** / **D** / **W**	
Home Address:	City:	State:	Zip:
Primary Phone:	(**Hm / Cell**)	Secondary Phone:	(**Hm /Cell**)
Employer:		Employer Phone:	
Appointment Reminders & Alerts Via: (**circle one**)	**Home Phone**	**Cell Phone**	**Text** **Email**
Email Address:			
If I cannot be reached (check one): ☐ Ok to leave a **detailed** message on**: Cell Hm Both** ☐ **Please only leave a message to return your call**			

In Case of Emergency

Name of friend/relative not living in your home:	
Phone Number:	**Relationship**:

Insurance Information

Primary Insurance Provider:	
Policy Number:	Group Number:
Subscriber's Name:	Subscriber's Birthdate:
Relationship to Subscriber (**Circle**): **Self / Spouse / Child / Other**	

Secondary Insurance Information

Secondary Insurance Provider (if applicable):	
Policy Number:	Group Number:
Subscriber's Name:	Subscriber's Birthdate:
Relationship to Subscriber (**Circle**): **Self / Spouse / Child / Other**	

Financial Policy

I understand, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand if I receive payment from my insurance carrier, when the payment should have come directly to our office, I am to bring the check and explanation of benefits to this office. I understand copays and balance due are to be paid, in full, prior to being seen. I authorize Anchor Bay Clinic Family Medical Center, as well as my insurance company, to release any medical information required to process my claim/s.

☒ **Signature:**	**Date:**