Methodist MEDICAL GROUP

REASON FOR VISIT

PATIENT INFORMATION

Name		Date of Birth	Sex
Address	City	State	Zip
Home Phone	Work	Cell	
Email Address	Social Security Number	Ok to Leave message at Home, Work, or Cell number? ○ Yes ○ No Which number?	
Employer Name/Address		Student Status ○ Full Time ○ Part Time ○ Not a Student	
Race ○ Black/African American ○ Asian ○ Caucasian ○ Hispanic or Latino ○ Other (*Please Specify)*			
Ethnicity: ○ Hispanic or Latino ○ Not Hispanic ○ Decline to Provide		Marital Status ○ Single ○ Married ○ Divorced ○ Widow	
Primary Language Spoken in the Home ○ English ○ Spanish ○ Other (please define):		Veteran ○ Yes ○ No	Smoker ○ Yes ○ No
Emergency Contact Name/ ADDR	**Relationship**	**Phone**	
Primary Care Doctor: Name, Address & Phone			
Preferred Pharmacy: Name, Address & Phone			

RESPONSIBLE PARTY/GUARANTOR INFORMATION IF DIFFERENT FROM ABOVE

NAME		Date of Birth	Relationship to Patient
Address	City	State	Zip
Phone Home/Cell	Work	**Social Security #:**	

PRIMARY INSURANCE

Insurance Company Name		Phone Number
Policy Number/Member ID Number		Group Number
Name of Insured	**Date of Birth**	Relationship to Patient ○ Self ○ Spouse ○ Parent ○ Other

SECONDARY INFURANCE IF APPLICABLE

Insurance Company Name			Phone Number
Policy Number/Member ID Number	Group Number	Relationship to Patient ○ Self ○ Spouse ○ Parent ○ Other	

HOW DID YOU HEAR ABOUT US?

○ Existing Patient (*Please Specify)* _____ ○ Family Referral (*Please Specify)* _____

○ Insurance ○ Billboard/Drive By ○ Employee ○ Direct Mail ○ Hospital Referred ○ Internet ○ Living Magazine ○ Other _____

With which lab is your insurance contracted (accepts)-? ○ LabCorp ○ Quest ○ CPL ○ Other (please define): _____

Please note: labs may be drawn in the office. However, it is your responsibility to know which lab your insurance accepts. Call your insurance prior to having blood work drawn to make sure that they will cover testing. **We are not responsible for third party bills related to services rendered.**

I certify that I have carefully reviewed this document, understand it, and have completed it truthfully.

_____ _____

Signature of Patient or Guardian Date