Welcome To Our Office

Date: _____

HR#: _____

We are committed to the best, most comprehensive care possible. We encourage you to ask questions, let us know your concerns and communicate openly with us. Please assist us by providing the following information. All information is confidential and is only released with your consent.

Patient Name: _____ D.O.B: _____ Age: _____

Sex: _____ Social Security #: _____Home Phone#: _____

Cell Phone: _____ Work Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

Address: _____

Phone #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Next of Kin: _____ Relationship: _____ Phone: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

If patient is a minor, responsible party's name: _____

Responsible Party's mailing address:

_____ Phone: _____

Who is your primary provider here at the HBMI Clinic? _____

Pharmacy Name: _____

Is your visit today work related? _____ If yes, what is your date of injury? _____

Workman's Compensation carrier: _____

Medical Insurance Company #1: _____

Subscriber: _____ Subscriber's Employer: _____

Certificate #: _____ Group #: _____

Insurance Address: _____

Medical Insurance Company #2: _____

Subscriber: _____ Subscriber's Employer: _____

Certificate #: _____ Group #: _____

Insurance Address: _____

Are you a veteran? ____No ____Yes

Ethnicity: _____

Primary Language spoken: _____

Migrant Worker: _____

Homeless? _____

Internet Access? _____ If yes, where? _____
Email address: _____

Preferred method of contact: _____

Number in household? _____

Household total income: _____

I authorize the HBMI Health Department to release information acquired in the course of my examination for treatment to any insurance carriers for insurance purposes only, and I authorize payment of my insurance benefits directly to the HBMI Health Department for professional services rendered.

Signature: _____ Date: _____

( ) **Copy of Insurance Card(s) Obtained**
Int: _____