PEAK PRIMARY CARE

Patient LAST NAME_____ FIRST NAME_____ M.I._____

SEX_____ BIRTHDATE _____/_____/_____ SOCIAL SECURITY NUMBER _____-_____-_____

HOME ADDRESS/P.O. BOX_____ APT/UNIT# _____

CITY _____ STATE _____ ZIP CODE _____-_____

Home (____) _____-_____ Cell (____) _____-_____ WORK PHONE (_____) _____-_____Ext_____

Preferred Language:_____Race_____Ethinicity: ___Non-Hispanic___Hispanic____Other

Email Address_____SPOUSE'S NAME_____

PATIENT EMPLOYER _____

Is the patient a college student? Yes___ No___ Full or Part Time? Name of School_____

Account Guarantor / Responsible Party

LAST NAME_____ FIRST NAME_____ M.I._____

SEX_____ BIRTHDATE _____/_____/_____ SOCIAL SECURITY NUMBER _____-_____-_____

HOME ADDRESS/P.O. BOX_____ APT/UNIT# _____

CITY _____ STATE _____ ZIP CODE _____-_____

HOME PHONE (_____) _____-_____ WORK PHONE (_____) _____-_____ EXT_____

Primary Insurance_____

Policy Holder: LAST NAME _____ **FIRST NAME** _____ **M.I.**_____

HOME ADDRESS/P.O. BOX_____ APT/UNIT# _____

CITY _____ STATE _____ ZIP CODE _____-_____

SEX _____ BIRTHDATE_____/_____/_____ SOCIAL SECURITY NUMBER _____-_____-_____

EMPLOYER NAME _____ PHONE NUMBER (_____) _____ Ext _____

EFFECTIVE DATE OF INSURANCE _____/_____/_____ RELATIONSHIP TO THE PATIENT?_____

ID# _____ GROUP# _____ COPAY $_____

Secondary Insurance Name: _____

Policy Holder: LAST NAME _____ FIRST NAME _____ M.I._____

SEX _____ BIRTHDATE_____/_____/_____ SOCIAL SECURITY NUMBER _____-_____-_____

EMPLOYER NAME _____ PHONE NUMBER (_____) _____ Ext_____

EFFECTIVE DATE OF INSURANCE _____/_____/_____ RELATIONSHIP TO THE PATIENT?_____

ID# _____ GROUP# _____ COPAY $_____

Local Emergency Contact_____ **Phone** (_____)_____

Relationship to patient _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND INFORMATION RELEASE: (1) I hereby authorize payment directly to the above-indicated physician of the surgical and/or medical benefits, and (2) authorize the release of any medical information necessary to process the medical claims. (3) I further state that I understand that I am responsible for any services not covered or denied by my insurance company and that it is my responsibility to know the covered benefits for my plan/plans.

X_____ Date _____/_____/_____