PATIENT INFORMATION

AFFINITY HEALTH GROUP

How did you hear about us?: ☐TV ☐Radio ☐Direct Mail ☐Newspaper ☐Friend/Family ☐Physician ☐Website ☐Health Fair

Referred by: _____ Family Doctor: _____

Patient's Name: _____
First Middle Last Preferred

Patient's Mailing Address: _____
Number and Street Apt/Lot City State Zip

SSN: ____–____–____ Date of Birth: _____ Marital Status: _____

☐ Male ☐ Female Race: _____ Language: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Best way to contact you: ☐ Phone ☐ Email Is this visit due to a work-related incident? ☐ Yes ☐ No

Employer: _____ Occupation: _____ School: _____

PAYMENT INFORMATION:

Person responsible for payment/bill: _____
First Middle Last

Address: _____ Main Phone: _____
Number and Street Apt/Lot City State Zip

Relationship to Patient: _____ SSN: ____–____–____ Date of Birth: _____

Best way to contact individual: ☐ Phone ☐ Mail Email Address: _____

INSURANCE INFORMATION:

Insurance Company: _____ Policy Number: _____

Policyholder's Name: _____
First Middle Last

Address: _____
Number and Street Apt/Lot City State Zip

Relationship to Patient: _____ SSN: ____–____–____ Date of Birth: _____

Main Phone: _____ 2nd Phone: _____ Email: _____

Employer: _____ Occupation: _____

2nd Insurance Company: _____ Policy Number: _____

PATIENT'S CONTACTS:

Pharmacy: _____ Location: _____

Legal Guardian: _____
Name Relationship Main Phone 2nd Phone

Primary Caregiver: _____
Name Relationship Main Phone 2nd Phone

Emergency Contact: _____
Name Relationship Main Phone 2nd Phone

All professional services rendered are the financial responsibility of the patient. Payment is expected upon the provision of services. For insured patients, we are pleased to assist in the filing of your insurance claims. *By signing below, I hereby consent to my insurance carrier releasing all necessary information to Affinity Health Group, LLC regarding the status of my claims. Further, I hereby authorize Affinity Health Group, LLC to furnish information to my insurance carrier concerning my medical history, illness and treatments. Further, I authorize my insurance carrier to pay directly to Affinity Health Group, LLC all benefits to which I and/or my dependents may be eligible for the provision of healthcare services.

I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS ABOVE

SIGNATURE: _____ **DATE:** _____

I hereby voluntarily give consent for the necessary medical treatment for the above named patient.

_____
SIGNATURE OF LEGAL GUARDIAN

_____
DATE