Family Physicians Group, PC

In order to help us keep our records on you as current as possible, please complete the following and return to your receptionist.

PATIENT INFORMATION – Please print legibly	
Name:	Email Address:
Address:	Race:
City: State: Zip:	Hispanic Non-Hispanic (circle one)
Home Phone Number:	Marital Status:
Cell Phone Number:	Primary Language:
Date of Birth:	Nickname:
Social Security Number:	Pharmacy & Location:
PATIENT EMPLOYER	**EMERGENCY CONTACT INFORMATION**
Employer Address	Emergency Contact:
City: State: Zip:	Emergency Contact Phone Number(s):
Work Phone Number:	Relationship to Patient:
Employment Status: Full time Part time Please circle one	**Student: Full time Part time N/A** please circle one
SPOUSE INFORMATION	
Name:	Date of Birth:
Spouse's Social Security Number:	
Spouse's Employer:	Employer Phone Number:
GUARANTOR or PARENT INFORMATION	
Name:	Date of Birth:
Address	Social Security Number:
City: State: Zip:	
Home Phone Number:	Employer:
Work Phone Number:	Employer Address:
Cell Phone Number:	Employer City: State: Zip:

Please present your insurance card to the receptionist. Presenting your insurance card does not guarantee submission by our office.

It is our policy that the patient is directly responsible for services when rendered. Please be advised that we do ask for payment at the time of service. You will receive a superbill to attach to your insurance claim form to file with your insurance.