TRIHEALTH PHYSICIAN PARTNERS

Patient Name: _____ **Today's Date** _____

Social Security Number: _____ **Sex:** (*Circle One) M F* ***Birth Date:*** _____

Street Address: _____ **Apt/Unit #** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Which Phone Number above is Your Primary Phone Number? *(Circle One) Home Work Mobile*

Do You Need an Interpreter? *(Circle One) Yes No* **Language:** _____

Marital Status: *Divorced Separated Married Single Widowed* **Religion:** _____

Ethnicity: *(Circle One) Hispanic Not Hispanic or Latino Refused*

Race: *(Circle One) African American/Black American Indian or Alaska Native Multi-Racial Asian Caucasian/White Native Hawaiian or Other Pacific Islander Other Declines to Answer*

How Did You Hear About Us? _____

In Case of Emergency, Please Contact:

Name: _____ **Relationship to Patient** _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Which Phone Number above is the Primary Phone Number? *(Circle One) Home Work Mobile*

Patient Employer: _____

Employment Status : (*Circle One)*

Full Time Part Time Retired Not Employed Student-Full Time Student – Part Time Disabled Self Employed On Active Military Duty Unknown

Do you have a Living Will? *Yes No*

D*o you have a Durable Power Of Attorney for Healthcare?* *Yes No*

If yes to either, please supply us with a copy for your file!

TRIHEALTH PHYSICIAN PARTNERS

1. **Primary Insurance Co. Name**_____

Policyholder Name: _____

Policyholder Date of Birth: _____ **Policyholder Relation to Patient:** _____

Policyholder's Employer: _____

Insurance Provided Through: *(Circle One)* *Current Employment* *COBRA* *Retirement* *Other*

Employer Size: *(Circle One)* *1-19* *20-99* *100+*

2. **Secondary Insurance Co. Name**_____

Policyholder Name: _____

Policyholder Date of Birth: _____ **Policyholder Relation to Patient:** _____

Policyholder's Employer: _____

Insurance Provided Through: *(Circle One)* *Current Employment* *COBRA* *Retirement* *Other*

Employer Size: *(Circle One)* *1-19* *20-99* *100+*

GUARANTOR INFORMATION

If the Patient is <u>Under Age 18,</u> Please Complete the Following:

Guarantor Name: _____ **Sex:** *M* *F* DOB:_____

Guarantor Relationship to Patient_____

Guarantor Address: _____

Guarantor Phone Number:_____

Guarantor Employer:_____

Employment Status : *Full Time* *Part Time* *Retired* *Not Employed* *Student-Full Time*

Student – Part Time *Disabled* *Self Employed* *On Active Military Duty* *Unknown*