PATIENT INFORMATION

ACACIA FAMILY MEDICAL GROUP

Today's Date: __________________

Name (Last, First, Middle Initial)		Other Names Used or Nickname	Gender
SSN	Marital Status	Date of Birth	
Race (circle one): African-American Asian Hispanic White Declined Other -			
Ethnic Group / Heritage: African American Indian Asian Central American Central American Indian European Mexican Pacific Islander South American South American Indian Decline Other:			
Language	Preferred Physician (circle one): Any Doctor in Group Dr. Acton Dr. Reddy Dr. Simon Dr. Siqueiros		
Home Address City State ZIP			
Circle your most preferred phone, for contact other than appointment reminders (lab results, follw up):	Home	Cell Number	Work Number
For Appointment Reminders (circle one): Home Phone, Cell Phone, Work Phone	E-mail	DL Number	DL Expiration and State
Emergency Contact (Last Name, First, Middle):		Phone	Relationship

Employment and Insurance Information

Employer		Work Phone		Employer Group Insurance? Yes No
Work Address		City		ZIP
Primary Insurance	Name of Subscriber	Subscriberøs DOB	Subscriberøs SSN	Relationship
		Policy ID	Group ID	
Secondary Insurance	Name of Subscriber	Subscriberøs DOB	Subscriberøs SSN	Relationship
		Policy ID	Group ID	

Guarantor Information- Please complete if patient is a minor or someone other than the patient is financially responsible.

Parent or Guardian (Last Name, First, Middle Initial)	DOB	Gender
	SSN	Relationship
Address	Phone (Home, Work, Cell)	
Other Parent or Guardian (Last Name, First, Middle Initial)	DOB	Gender
	SSN	Relationship
Address	Phone (Home, Work, Cell)	

Patient Authorization

I hereby give authorization for payment of insurance benefits to be made directly to the physician and any assisting physicians, for services rendered and authorize physician and clinic to release any information to process insurance claim. I also agree to pay bills unless other arrangements are made.

Signature ____ Date ___________________

Responsible Party of Minor____ Date __________________