PRIMARY CARE PARTNERS   **POLICY AND PAYMENT DATA FORM**

PATIENT NAME: _____ **DATE OF BIRTH**:_____/_____/_____
                          Last   First   M.I.

SEX: □ Male   □ Female   □ Decline   **SOCIAL SECURITY #**: _____ - _____ - _____

MARITAL STATUS: □ Single   □ Married   □ Divorced   □ Separated   □ Widowed

RACE: □ African American   □ American Indian   □ Asian   □ White   □ Other   □ Decline

ETHNICITY: □ Hispanic / Latino   □ NON Hispanic / Latino   □ Decline

PREFERRED LANGUAGE: □ Arabic □ Chinese □ English □ Spanish □ Russian □ Vietnamese □ Other_____

PRIMARY PROVIDER: □ Dr. Hurlbut □ Dr. Webb □ Dr. DeNell □ Dr. Majerus □ Dr. Blake □ Dr. Dodge □ Dr. Johnson
                □ Dr. Wilson   □ Angela Zavala DNP   □ Kerri Purkeypile NP   □ Ashley Gunderson PA

PATIENT'S ADDRESS: _____
                                    Street   City   State   Zip

PATIENT'S PHONE / E-MAIL: Fill out **ALL** numbers and **check the box for preferred method of contact/electronic reminders.**

□ Home Phone: _____   □ Work Phone: _____

□ Cell Phone: _____ Call **or** Text   □ E-mail (Portal): _____

PERSON RESPONSIBLE FOR THE BILL: ***Please fill out if Self is NOT marked.**

□ **Self**   OR   □ **Spouse***   Name: _____

              □ **Parent/Guardian***   DOB: _____/_____/_____   Phone: _____

                                          Billing Address: _____
                                                              Street   City   State   Zip

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PATIENT MUST FILL OUT ALL INSURANCE INFORMATION

Primary Insurance:_____	**Secondary Insurance**:_____
Policy Holder Name:_____	Policy Holder Name:_____
Relationship to Policy Holder: _____	Relationship to Policy Holder: _____
DOB:___/___/___ SSN:_____-___-_____	DOB:___/___/___ SSN:_____-___-_____
Group:_____ Policy #:_____	Group:_____ Policy #:_____

CONTACTS:

Spouse's Name: _____   Spouse's Cell #: _____

Spouse's Employer: _____   Spouse's Work #: _____

If patient is a minor or on parent's insurance:

Father: _____   Mother: _____

Address: _____   Address: _____

Cell #: _____   Cell #: _____

Work #: _____   Work #: _____

Employer: _____   Employer: _____

EMERGENCY CONTACT (Nearest friend or relative not living in the same household):

Name: _____ Phone: _____ Relationship:_____

PREFERRED HOSPITAL: □ Bryan Health Systems East   □ Bryan Health Systems West   □ St. Elizabeth's (CHI)

PATIENT EMPLOYMENT: □ Full-time □ Part-time **Employer Name**: _____
                        □ Student   □ Retired   □ Self-Employed

Reviewed:_____