PRIMARY CARE PARTNERS

POLICY AND PAYMENT DATA FORM

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 PHYSICIAN: Dr. Webb Dr. DeNell Dr. Majerus Dr. Blake Dr. Wilson Dr. Johnson Dr Hutc A. Zavala APRN K. Dannewitz APRN A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-C PATIENT'S ADDRESS: Street City State Zip PATIENT'S PHONE / E-MAIL: Please fill out ALL numbers and check the box for preferred method of contact. Home Phone: Work Phone: Cell Phone: E-mail (Portal): PERSON RESPONSIBLE FOR THE BILL: *Please fill out if Self is NOT marked. Billing Address: Billing Address:	PATIENT NAME: _		DATE	or bikin	_′′
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 PHYSICIAN: Dr. Webb Dr. DeNell Dr. Majerus Dr. Blake Dr. Wilson Dr. Johnson Dr Hutc	SEX: □ Male □		M.I. SOCIAL SECURITY #	_	_
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					
ETHNICITY: Hispanic / Latino			1		
PREFERRED LANGUAGE: Arabic Chinese English Spanish Russian Vietnamese Other PRIMARY PHYSICIAN: Dr. Webb Dr. DeNell Dr. Majerus Dr. Blake Dr. Wilson Dr. Johnson Dr. Hutci A. Zavala APRN K. Dannewitz APRN A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-C PATIENT'S ADDRESS:					
PRIMARY PHYSICIAN: Dr. Webb Dr. DeNell Dr. Majerus Dr. Blake Dr. Wilson Dr. Johnson Dr Hutch A. Zavala APRN K. Dannewitz APRN A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Bokowski APRN K. Pfeffer APRN A. Gunderson PA-Comparison A. Gunderson	-	-		□ Vietnamese □ Ot	her
A. Zavala APRN					
PATIENT'S PHONE / E-MAIL: Please fill out ALL numbers and check the box for preferred method of contact. Home Phone:			ž		
PATIENT'S PHONE / E-MAIL: Please fill out ALL numbers and check the box for preferred method of contact. Home Phone:	PATIENT'S ADDRE	ESS:			
□ Home Phone: □ Work Phone: □ E-mail (Portal): □ E					r
Cell Phone:			-		
PERSON RESPONSIBLE FOR THE BILL: *Please fill out if Self is NOT marked. Self OR Spouse* Name: Phone:					
Self OR Spouse* Name: Parent/Guardian* DOB: / Phone:	□ Cell Phone:				
Parent/Guardian* DOB:/ Phone:		SIBLE FOR THE BILL:	*Please fill out if Self is NOT marke	ed.	
Billing Address: Street City State Zip	□ Self OR	•			
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: Relationship to Policy Holder: Page 14 Policy Holder: Relationship to Policy Holder: Rel		□ Parent/Guardian*	DOB:/ Ph	none:	
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: Relationship to Policy Holder: Page 14 Policy Holder: Relationship to Policy Holder: Rel		*** **** *****			
DOB:SSN:=DOB:/SSN:=	Policy Holder Name:_	PATIENT MUST FIL	Billing Address:Street L OUT ALL INSURANCE INFOI Secondary Insurance: Policy Holder Name:	RMATION	
DOB: / / SSN: = = = DOB: / / SSN: = = =		PATIENT MUST FII	Billing Address:Street L OUT ALL INSURANCE INFOI Secondary Insurance:	RMATION	
	Policy Holder Name:_ Relationship to Policy	PATIENT MUST FIL	Billing Address: Street COUT ALL INSURANCE INFO Secondary Insurance: Policy Holder Name: Relationship to Policy Ho	RMATION older:	
Group: Policy #: Group: Policy #:	Policy Holder Name:_ Relationship to Policy DOB:/	PATIENT MUST FII Holder: SSN:	Billing Address: Street L OUT ALL INSURANCE INFOI Secondary Insurance: Policy Holder Name: Relationship to Policy Holder DOB: /	RMATION older:SSN:	÷
	Policy Holder Name: Relationship to Policy DOB: Group: CONTACTS:	PATIENT MUST FILE Holder: SSN: Policy #:	Billing Address: Street L OUT ALL INSURANCE INFOI Secondary Insurance: Policy Holder Name: Relationship to Policy Holder DOB: Group:	RMATION older: SSN: Policy #:	-
	Policy Holder Name: Relationship to Policy DOB: Group: CONTACTS: Spouse's Name:	PATIENT MUST FII Holder: SSN: Policy #:	Billing Address: Street L OUT ALL INSURANCE INFOI Secondary Insurance: Policy Holder Name: Relationship to Policy Holder DOB: Group: Spouse's Cell #:	RMATION older:SSN:= Policy #:	-
	Policy Holder Name: Relationship to Policy DOB: Group: CONTACTS: Spouse's Name:	PATIENT MUST FII Holder: SSN: Policy #:	Billing Address: Street L OUT ALL INSURANCE INFOI Secondary Insurance: Policy Holder Name: Relationship to Policy Holder DOB: Group: Spouse's Cell #:	RMATION older:SSN:= Policy #:	-
Spouse's Employer: Spouse's Work #:	Policy Holder Name: Relationship to Policy DOB: Group: CONTACTS: Spouse's Employer: Spouse's Employer:	PATIENT MUST FIL Holder: SSN: Policy #:	Billing Address: Street L OUT ALL INSURANCE INFOI Secondary Insurance: Policy Holder Name: Relationship to Policy Holder DOB: Group: Spouse's Cell #:	RMATION older:SSN:= Policy #:	-
Spouse's Employer: Spouse's Work #: f patient is a minor or on parent's insurance:	Policy Holder Name: Relationship to Policy DOB: Group: CONTACTS: Spouse's Name: Spouse's Employer: f patient is a minor or	PATIENT MUST FII Holder: SSN: Policy #: r on parent's insurance:	Billing Address:Street L OUT ALL INSURANCE INFOI Secondary Insurance: Policy Holder Name: Relationship to Policy Holder DOB:/ Group: Spouse's Cell #: Spouse's Work #:	RMATION older: SSN: Policy #:	-
spouse's Employer: Spouse's Work #: f patient is a minor or on parent's insurance: father: Mother:	Policy Holder Name: Relationship to Policy DOB: Group: CONTACTS: Spouse's Name: Spouse's Employer: Spouse's Employer: Grather:	PATIENT MUST FII Holder: SSN: Policy #:	Billing Address:Street L OUT ALL INSURANCE INFOI Secondary Insurance: Policy Holder Name: Relationship to Policy Holder DOB:/ Group: Spouse's Cell #: Spouse's Work #: Mother:	RMATION older:SSN: Policy #:	<u>-</u>
Spouse's Employer: Spouse's Work #: f patient is a minor or on parent's insurance: Sather: Mother: Address: Address:	Policy Holder Name: Relationship to Policy DOB: Group: CONTACTS: Spouse's Name: Spouse's Employer: f patient is a minor or Cather:	PATIENT MUST FII Holder: SSN: Policy #:	Billing Address:Street LOUT ALL INSURANCE INFOI Secondary Insurance: Policy Holder Name: Relationship to Policy Holder DOB: / Group: Spouse's Cell #: Spouse's Work #: Mother: Address: Address:	RMATION older: SSN: Policy #:	<u>-</u>
Spouse's Employer: Spouse's Work #: f patient is a minor or on parent's insurance: Stather: Mother: Address: Address: Cell #: Cell #:	Policy Holder Name: Relationship to Policy DOB: Group: CONTACTS: Spouse's Name: Spouse's Employer: f patient is a minor of Sather: Address: Cell #:	PATIENT MUST FILE / Holder: / SSN: = Policy #: r on parent's insurance:	Billing Address:Street L OUT ALL INSURANCE INFOI Secondary Insurance: Policy Holder Name: Relationship to Policy Holder DOB:/ Group: Spouse's Cell #: Mother: Address: Cell #:	RMATION older:	
Spouse's Employer: Spouse's Work #: Mother: Address: Cell #: Cell #: Work #: Work #: Work #: Work #: Spouse's Work #: Spo	Policy Holder Name: Relationship to Policy DOB: Group: CONTACTS: Spouse's Name: Spouse's Employer: f patient is a minor or Sather: Cell #: Vork #:	PATIENT MUST FII Holder: SSN: Policy #:	Billing Address:Street L OUT ALL INSURANCE INFOI Secondary Insurance:Policy Holder Name:Relationship to Policy Holder DOB:/ Group:Spouse's Cell #:Spouse's Work #:Mother:Address:Cell #: Work #:	RMATION older: SSN: Policy #:	<u>-</u>
Address:	Policy Holder Name: Relationship to Policy DOB: Group: CONTACTS: Spouse's Name: Spouse's Employer: ddress: Cell #: Work #: Employer:	PATIENT MUST FII Holder: SSN: Policy #:	Billing Address:Street L OUT ALL INSURANCE INFOI Secondary Insurance: Policy Holder Name: Relationship to Policy Holder DOB: / Group: Spouse's Cell #: Spouse's Work #: Address: Cell #: Work #: Employer: Employer:	RMATION older: SSN: Policy #:	<u>-</u>

□ Student □ Retired □ Self-Employed