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 PHYSICIAN: □ Dr. Webb □ Dr. DeNell □ Dr. Majerus □ Dr. Blake □ Dr. Wilson □ Dr. Johnson □ Dr Hutchins
□ 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.**

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

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

Billing Address: _____
Street City State Zip

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