



University Health Associates

Harpers Ferry Family Medicine

Patient Information:

Name: (First) _____ (MI) _____ (Last) _____

Social Security # _____ - _____ - _____ Sex: M F Date of Birth ____/____/____

Address: _____

(Include City, State and Zip Code)

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Email: _____

Marital Status: (circle one) Divorced, Married, Single, Separated, Other, Significant Other, Widow

Religion: _____ Race: _____

Employer: _____ Employer's Address: _____

Date of Employment: __/__/__ Occupation: _____

Employment Status: (circle one)

Disabled Full-time Part-time Not employed Self-employed Retired Student

Work Phone: (____) _____ EXT _____ Work Fax (____) _____

EMERGENCY CONTACT(1)

Name: _____ Date of Birth ____/____/____

Address: _____

Phone # (____) _____ Employer Phone: (____) _____ Cell # (____) _____

Relation to Patient: _____

EMERGENCY CONTACT (2) Relative or Friend Not Living With You:

Name: _____ Date of Birth ____/____/____

Address: _____

Phone # (____) _____ Employer Phone: (____) _____ Cell # (____) _____

Relation to Patient: _____ **(OVER)**

GUARANTOR

GUARANTOR IS THE PERSON RESPONSIBLE FOR CHARGES FOR THE PATIENT AND OTHER FAMILY MEMBERS.

MUST BE COMPLETED IF PATIENT IS UNDER 18 YEARS OLD

CHECK HERE IF SAME AS PATIENT

Name: _____

Relation to Patient: _____

Address: _____

Social Security # _____ - _____ - _____

Date of Birth ____/____/____

Phone# _____ - _____ - _____

Employer: _____

Address: _____

Employment Status: Circle one Full Time Part Time Laid Off Not Employed Retired Self Employed

Student/FT Student/PT Unknown

Employment Date: _____ Occupation _____

Employer Phone: (____) _____ Ext: _____

INSURANCE COVERAGE PRIMARY

INSURANCE COMPANY _____

GROUP # _____

Claims Mailing Address: _____

ID# _____

Subscribers Employer: _____

Employer Phone: (____) _____

Coverage through: Circle One Current Employment Retirement COBRA/Continuation of Benefits Other

Employer Size: Circle One 1-19 20-99 100+ Employees

Subscribers Name: _____

Date of Birth ____/____/____

Address: _____

Phone # (____) _____

Cell # (____) _____

Effective Date of Insurance _____

Relationship to Patient: Circle one Self Spouse Mother Father Step Mother Step Father Ex-Spouse Foster Child

Other (specify) _____

If you have secondary insurance please ask staff for additional coverage sheet.

I hereby assign, transfer and set over to University Health Associates, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature: _____ Date: _____

Please provide proof of insurance at every visit.

INSURANCE COVERAGE SECONDARY

INSURANCE COMPANY _____ GROUP # _____

Claims Mailing Address: _____ ID# _____

Subscribers Employer: _____ Employer Phone: (____) _____

Coverage through: Circle One Current Employment Retirement COBRA/Continuation of Benefits Other

Employer Size: Circle One 1-19 20-99 100+ Employees

Subscribers Name: _____ Date of Birth ____/____/____

Address: _____ Phone # (____) _____

Cell # (____) _____

Effective Date of Insurance _____

Relationship to Patient: Circle one Self Spouse Mother Father Step Mother Step Father Ex-Spouse Foster Child
Other (specify) _____