FAMILY FIRST HEALTH CARE YALE - LEXINGTON
familyfirsthealthcare.net

[ALL FIELDS MUST BE FILLED OUT IN THEIR ENTIRETY]

Patient **Last Name** **First Name** **Middle Initial**

Address **Apt./P.O. Box** **City** **State** **Zip**

Home Phone **Cell Phone** **Email Address**

Sex **D.O.B.** **Age** **Marital Status** **Race/Ethnicity** **Language Spoken**

Parent/Guardian Name (if patient is under the age of 18) **Parent Address (if different from the patient)**

Employer **Address** **Occupation**

Name Emergency Contact **Emergency Contact Phone Number**

Preferred Pharmacy **Pharmacy Phone**

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

Name of Primary Insurance Holder **D.O.B.** **SS#**

Address (if different from Patient) **City** **State** **Zip**

Employer **Employer Address/Phone**

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE CARRIER

Name of Secondary Insurance Holder **D.O.B.** **SS#**

Address (if different from Patient) **City** **State** **Zip**

Employer **Employer Address/Phone**

THE FOLLOWING STATEMENT MUST BE SIGNED PRIOR TO TREATMENT

I have completed this form completely and certify that I am the patient or the duly authorized general agent of the patient. I authorize the release of pertinent medical information to my insurance carrier and authorize my insurance benefits to be paid directly to Family First Health Care-Yale, PLLC. I understand that even though I may have insurance coverage, I am responsible for payment of all services rendered that are not covered under my insurance policy.

Today's Date **Signature of Patient, or Responsible Party**

PLEASE PRESENT ALL INSURANCE CARDS AND DRIVERS LICENSE ALONG WITH THIS COMPLETED FORM TO THE FRONT DESK