Orange Family Physicians Patient Information

We appreciate you taking a few minutes to "update" your information even it it is "the same". We take your health care seriously. Doing your part verifies how to reach you, accurately bill for services and keeps us HIPAA compliant. Thank you for taking the time to do this!

Patient's name _____
Last *First* *Middle/maiden*

Soc. Sec. No. _____**Birth date**_____ **Gender** _____ **Marital Status**_____

Race_____ **Ethnic Group** _____ **Language**_____
(Not Hispanic/Hispanic/Latino)

Mailing Address_____**City**_____**State**_____ **Zip**_____

Physical Address _____**City** _____**State** _____ **Zip** _____

Email Address _____**Home phone** _____ **Cell phone**_____

***Preferred method of contact:** _____

If patient is a minor (under age 18), guarantor's name _____

Guarantor's birth date_____ ***Guarantor's Soc Sec No***_____ ***Relationship to child***_____

Address (if different from above) _____

City _____***State*** _____ ***Zip*** _____ ***Phone*** _____

Employer: _____**Phone** _____

***Can you be reached at work in the event of an urgent or emergent matter?** _____

In case of emergency, notify:

Name _____***Relationship*** _____***Phone***_____

Address _____***City*** _____***State*** _____ ***Zip***_____

Payment & Insurance Information

***If current insurance card provided, please write "see Insurance Card". If "Self-Pay", please write "Self-Pay"**

Insurance Company_____

Policy number_____ **Group number**_____

Name of Policy Holder_____ **Birth date** _____

I authorize the release of any medical information necessary to process my claims. I authorize payment of medical benefits to Orange Family Physicians for services received. A photocopy of my signature will serve as an original.

Signed_____**Date** _____
(Guarantor may sign if patient is a minor)

PLEASE SIGN THE FINANCIAL POLICY ON THE BACK

Updated 2/2020