AGAPÉ PHYSICIANS CARE

Practitioner: ____________________

Patient Information

First Name ____________ Middle Name ____________ Last Name ____________

SSN: ______________________ Date of Birth: ______________ Sex: □ M □ F

Marital Status (check one): □ Single □ Married □ Divorced □ Widowed □ Life Partner □ Separated □ Unknown

Address: ______________________________

City: ______________________ State: ____________ Zip Code: ____________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Ethnic Origin (check one): □ American Indian □ Asian □ Black □ Hispanic □ White □ Other

E-Mail Address: ______________________ Primary Language: ______________

Emergency Contact Information

Name: ______________________ Date of Birth: ______________

Relationship to Patient: ______________________ Phone Number: ______________

E-Mail Address: ______________________

Guarantor Information (Financially Responsible Party)

Please check here if information is same as above □

First Name ____________ Middle Name ____________ Last Name ____________

SSN: ______________________ Date of Birth: ______________

Address: ______________________________

City: ______________________ State: ____________ Zip Code: ____________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Guarantor's Relationship to Patient: ______________________

Guarantor's E-Mail Address: ______________________

Primary Insurance Information

Please attach a copy of all insurance cards

Release Information

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for any amount not covered by my insurance. I request that payment of authorized Medicare benefits be made to my physician.

Signature of Patient/Representative______________________ Date: ______________