PATIENT INFORMATION

NAME (Last, First, Middle Initial)		SSN#	BIRTHDATE	GENDER ☐ MALE ☐ FEMALE
ADDRESS		CITY, STATE, ZIP		
PRIMARY PHONE - May we leave a detailed message at this phone? ☐ Yes ☐ No		EMAIL ADDRESS		
EMPLOYER		WORK PHONE NUMBER May we leave a detailed message at this phone? ☐ Yes ☐ No		

GUARANTOR INFORMATION

NAME (Last, First, Middle Initial)		SSN#	BIRTHDATE	GENDER ☐ MALE ☐ FEMALE
ADDRESS (if different from patient)		CITY, STATE, ZIP		
PRIMARY PHONE - May we leave a detailed message at this phone? ☐ Yes ☐ No		EMAIL ADDRESS		
EMPLOYER		WORK PHONE NUMBER May we leave a detailed message at this phone? ☐ Yes ☐ No		RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ GUARDIAN

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY NUMBER	GROUP NUMBER
NAME OF POLICY HOLDER		RELATIONSHIP TO PATIENT	
POLICY HOLDER DATE OF BIRTH	GENDER ☐ MALE ☐ FEMALE	POLICY HOLDER EMPLOYER	
COPAY AMOUNT	DEDUCTIBLE AMOUNT	INSURANCE COMPANY PHONE #	

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY NUMBER	GROUP NUMBER
NAME OF POLICY HOLDER		RELATIONSHIP TO PATIENT	
POLICY HOLDER DATE OF BIRTH	GENDER ☐ MALE ☐ FEMALE	POLICY HOLDER EMPLOYER	
COPAY AMOUNT	DEDUCTIBLE AMOUNT	INSURANCE COMPANY PHONE #	

AUTHORIZED INDIVIDUALS (List of individuals authorized to receive medical information and financial information)

NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE

PHARMACY INFORMATION

NAME OF PHARMACY

ADDRESS

MAIL-ORDER PHARMACY INFORMATION

NAME OF PHARMACY

ADDRESS

OTHER INFORMATION

PRIMARY LANGUAGE OF PATIENT	ETHNICITY	RACE
☐ English	☐ Hispanic or Latino	☐ American Indian/Alaska Native/Native Hawaiian
☐ Spanish	☐ Not Hispanic or Latino	☐ Asian
☐ Other _____	☐ Unreported/Refused to Report	☐ Other Pacific Islander
		☐ Black/African American
		☐ Unreported/Refused to Report
		☐ More than one Race
		☐ White (Caucasian)

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to **PEBBLE CREEK MEDICAL GROUP**. I also authorize PEBBLE CREEK MEDICAL GROUP PLLC to release any information required to process my claims. I also understand that any and all changes to the above information must be presented to **PEBBLE CREEK MEDICAL GROUP PLLC** in writing.

_____ _____

Patient Name (Please print) Date of Birth

_____

Signature of Patient or Parent/Guardian

_____

Printed Name of Parent or Guardian

_____

Date