 **BELLBROOK FAMILY PRACTICE**

**Patient Information Form**

Today’s Date \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Biological Sex M F Gender Identity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Pronoun\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Relationship Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_

Home Phone ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Number ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Ext\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request Portal Access YES NO

**Language** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race** White \_\_\_\_\_ African American \_\_\_\_\_ Asian \_\_\_\_\_\_ American Indian \_\_\_\_\_\_

European \_\_\_\_\_ Other \_\_\_\_\_\_ Decline \_\_\_\_\_\_

**Ethnicity** Hispanic Latino/Spanish \_\_\_\_\_\_ Non-Hispanic Latino/Spanish \_\_\_\_\_\_ Decline \_\_\_\_\_\_

**Veteran** YES NO **Active Duty** YES NO

**Insurance Information**

Primary Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_

Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Co-Pay \_\_\_\_\_\_\_\_\_\_

Secondary Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_

Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Co-Pay \_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Minor/Guardian (if applicable)**

Legal Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_

Home Phone ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

**Guardianship Authorization (if applicable)**

I give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_my permission to bring my child(s)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Bellbrook Family Practice for medical care and treatment.

I give Bellbrook Family Practice my permission to evaluate and treat the above name child(s) in my absence.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature Guardian Name (please print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

**Authorization**

* **I hereby authorize Bellbrook Family Practice to apply for benefits on my behalf for covered services rendered by the physicians or their orders, realizing that I am responsible to pay for medical services. I request that payment from my insurance company be made directly to the physician.**
* **I authorize the release of any pertinent medical information to insurance carriers form consulting physicians.**
* **I authorize Bellbrook Family Practice to pertinent medical information to consulting physicians.**
* **I certify that the information I have reported regarding my insurance company is correct. Either my insurance company or I may revoke this authorization at any time in writing.**
* **I permit a copy of any of these authorizations be used in place of the original.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**

**Patient/Legal Guardian Signature Date**