GRAHAM
MEDICAL ASSOCIATES

PATIENT INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: ____ / ____ / _____ SEX: ☐ MALE ☐ FEMALE ☐ OTHER SSN: XXX-XX- _____

PATIENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

(Please check the box to indicate your preferred means of communication)

☐ HOME PHONE: _____ ☐ WORK PHONE: _____

☐ CELL PHONE: _____ ☐ EMAIL: _____

EMPLOYER: _____ MARITAL STATUS: _____

RACE: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK/AFRICAN AMERICAN ☐ WHITE/CAUCASIAN ☐ ASIAN

☐ HAWAIIAN/PACIFIC ISLANDER ☐ OTHER ☐ UNKNOWN ☐ DECLINED

ETHNICITY: ☐ NOT HISPANIC OR LATINO ☐ HISPANIC OR LATINO ☐ DECLINED ☐ UNKNOWN

LANGUAGE: _____ ☐ INTERPRETER NEEDED: _____

SPOUSE'S NAME: _____ SPOUSE'S DATE OF BIRTH: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ OTHER PHONE: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID#: _____ GROUP #: _____ PLAN #: _____

SECONDARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

OTHER INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **GRAHAM MEDICAL ASSOCIATES.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

SIGNED: _____ DATE: _____

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-123-456-7890 (TTY: 1-123-456-7891).
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-123-456-7890 (TTY: 1-123-456-7891).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-123-456-7890（TTY：1-123-456-7891）。