FIRST 1ST Health
MEDICAL CENTER of Fresno inc.

PATIENT INFORMATION

DATE:_____/_____/_____

SOCIAL SECURITY # _____ HOME ADDRESS _____

FIRST NAME _____ MI _____ _____

LAST NAME _____ CITY _____ STATE _____ ZIP _____

SEX_____ DATE OF BIRTH _____ HOME PHONE _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE WORK PHONE _____

☐ DIVORCED ☐ WIDOWED CELL PHONE _____

(CHECK ONE) ☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT

PARENT/GUARDIAN NAME (IF PATIENT IS A MINOR) _____

HOME PHONE _____ CELL PHONE _____

EMPLOYER _____ PRIMARY DOCTOR _____

REASON FOR TODAY'S VISIT _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK

☐ COMMERCIAL ☐ MEDICARE ☐ MEDI-CAL (WE DO NOT ACCEPT) ☐ WORKERS COMPENSATION ☐ OTHER _____

PRIMARY INSURANCE COMPANY _____

SUBSCRIBER'S NAME _____ RELATIONSHIP _____

MEMBER ID# _____ GROUP# _____

SECONDARY INSURANCE COMPANY _____

SUBSCRIBER'S NAME _____ RELATIONSHIP _____

MEMBER ID# _____ GROUP# _____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____

SOCIAL SECURITY # _____ DOB _____ SEX _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to the Physician of the medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process claims.

Patient's Signature_____ Date _____