Patient Information Form

Patient Name: ____

Last Name First Name Middle

Preferred Name: ______________________________________

Date of Birth: _____/_____/_____ **SS Number:**________-______-________

Street Address Line 1: ____

Street Address Line 2: ____

City:______________________________ **State:** _____________ **Zip code:**________________________

Home Phone: (_____) ________________________ **Cell Phone:** (____) ___________________________

Work Phone: (_____) ________________________ **Email:** ____________________________________

Emergency Contact Name: ___________________________ **Phone:** (_____) ___________________

☐ I would like to register for the Careteam+ patient portal.

☐ I decline to register for the patient portal at this time.

Marital Status:

☐ Single ☐ Divorced

☐ Married ☐ Widowed

☐ Separated ☐ Domestic Partnership

Race:

☐ American Indian or Alaska Native ☐ Native Hawaiian

☐ Other Pacific Islander

☐ Black or African American ☐ Caucasian or White

☐ Asian ☐ Choose not to disclose

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Choose not to disclose

Primary Language:____

Do you need an interpreter? ☐ yes ☐ no

DO YOU CURRENTLY HAVE HEALTH INSURANCE? Y / N **** A COPY OF YOU INSURANCE CARD AND PHOTO ID IS REQUIRED****

PRIMARY INSURANCE:____ EFFECTIVE DATE:_______________

POLICY HOLDER NAME:__________________________________POLICY HOLDER DOB:____________________

POLICY HOLDER RELATIONSHIP TO PATIENT:___________________________________

POLICY #:____________________________________ GROUP # OR NAME:___________________________________

SECONDARY INSURANCE:____ EFFECTIVE DATE:_______________

POLICY HOLDER NAME:__________________________________POLICY HOLDER DOB:____________________

POLICY HOLDER RELATIONSHIP TO PATIENT:___________________________________

POLICY #:____________________________________ GROUP # OR NAME:___________________________________

Sliding Fee Scale Program

Careteam+ offers a sliding fee scale to patients. Participation in the sliding fee scale program is not required. Eligibility is based on household size and income. Please check one of the options below:

☐ I wish to participate in the sliding fee scale program

☐ I have been offered, but decline to participate in the sliding fee scale program.

☐ I wish to participate in the sliding fee scale program, but do not have the documentation required to complete an application today. I will return with the required documentation within 30 days to qualify for the sliding fee scale program.

Patient Responsibilities

*__Patient is responsible for all medical services rendered regardless of insurance coverage__.
*__Patient is responsible for co-pay at time of visit.__
*__Patient may also be responsible for payment of office visit until deductible is met. Patient may be charged for the office visit and / or associated costs after insurance adjustments.__
*Patient may be responsible for obtaining a referral from their Primary Care Physician or Insurance Company in order to be seen.
*If referral is not obtained, patient will be responsible for payment of services rendered.
*Should any of the above information change, please notify our office immediately.

I have read and agree to these terms.
Patient's Printed Name: ___________________________ **Date of Birth**_____________________
Signature: __________________________________ Date: ________________________

How Did You Hear About Us?
Please Check ALL That Apply.

Billboard ☐	TV ☐	Radio ☐
Postcard ☐	Magazine Ad ☐	Internet ☐
Newspaper ☐	Facebook ☐	Instagram ☐
Article ☐	Referral ☐	Twitter ☐
Flyer ☐	Community Presentation ☐	Don’t Remember ☐