Welcome to Associates in Family Practice, PLLC

42755 Mound Road, Sterling Heights, MI 48314

Please Print & Fill Out Completely

and sign the statements on the back of this form

(This form is to be updated yearly or with any information changes)

Patient Name:____ **Date of Birth:** ___________________
Last First MI

Social Security#: ___________________________ **Gender:** Male ☐ Female ☐ **Marital Status:** S ☐ M ☐ D ☐ W ☐

Race: _________________ **Ethnicity:** Hispanic or Latino ☐ NON Hispanic or Latino ☐ **Language:** _____________________

Home Address: ____
Street City State Zip

Home Phone: __________________________ **Cell:** ________________________ **Preferred Contact #** Home ☐ Cell ☐ Wk ☐

Employer: ____ **Work Phone**: __________________________________

Referred by:____ **E-Mail:** ____

SPOUSE / or RESPONSIBLE PARTY if Pt is under 18

Name: ____ **Date of Birth**: ______________________
Last First MI

Home Address: ____
Street City State Zip

Social Security#: ___________________________ **Home Phone:** ______________________ **Cell Phone:** ______________________

Employer: ____ **Work Phone:** ____________________________________

EMERGENCY CONTACT

Name/ Relationship:____ **Phone:** ___________________________

Name/ Relationship:____ **Phone:** ___________________________

INSURANCE INFORMATION

PRIMARY

Insurance Co: ____ **Policy Holder's SSN:** ___________________________

Policy Holder/Relationship: ____ **Policy Holder's DOB**: _____________________

SECONDARY

Insurance Co: ____ **Policy Holder's SSN:** ___________________________

Policy Holder/Relationship: ____ **Policy Holder's DOB**: _______________________

PLEASE COMPLETE BOTH SIDES OF THIS FORM

PRIVACY POLICY

The undersigned Patient or Authorized Representative of the Patient acknowledges that he or she personally received a copy of Associates in Family Practice, PLLC's Notice of Privacy Policies on the date indicated below.

RELEASE OF MEDICAL INFORMATION / ASSIGNMENT OF BENEFITS

I authorize Associates in Family Practice, PLLC to release and/or obtain any medical records concerning myself to/from any physician, hospital, or agency for continuation of my medical care.

I hereby consent to the release of medical information necessary to process all insurance claims.
I authorize my insurance carrier to assign all medical benefits applicable to Associates in Family Practice, PLLC

PERSONAL HEALTH INFORMATION

I hereby give my permission to Associates in Family Practice, PLLC to speak with the individual(s) listed below regarding my care / account:

Name ____________________________________ Relationship___________________________

Name ___________________________________ Relationship___________________________

Name ____________________________________ Relationship___________________________

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE RELEASES, AUTHORIZATIONS AND ACKNOWLEDGMENTS.

I UNDERSTAND THAT A PHOTO COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

____ Date ______________________
Signature of patient or Responsible Party

Patient Name (PLEASE PRINT) ____