NORTH LIBERTY FAMILY HEALTH CENTRE, P.C.

Today's Date: _____

ABOUT THE PATIENT (If the patient is a minor or NOT the insured party, please also fill out back side):

Preferred Provider: Dr. _____ **Preferred Pharmacy (and location):** _____

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Preferred Name: _____ **Maiden Name:** _____

DOB: _____/_____/_____ **Sex:** M/F **SSN:** _____-_____-_____ **Prim. Language:** _____

Race: American Indian/Alaska Native ____ Asian _____ Black/African American ____

Native Hawaiian/Pacific Islander ____ Other Race ____

White _____ Declined ____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____

Widowed _____ Partnered _____

Spouse's/Partner's Name: _____

Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____ Declined _____

Mailing Address: _____

Zip Code: _____ **City:** _____ **State:** _____ **County:** _____

Phone numbers: **Please indicate if it is okay to call you at these numbers by circling Yor N:

Home: _____ Y/N Primary work: _____ Y/N

Cell: _____ Y/N Primary: _____ Y/N

Employer: _____ **Occupation:** _____

Emergency Contact:

Name: _____ Relationship to Patient: _____ Phone: _____

Insurance: Primary Insurance Company _____

Primary Insurance Policy Holder Information:

Name: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

Employer: _____ Relationship to Patient: _____

Secondary Insurance Company _____

Secondary Insurance Policy Holder Information:

Name: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

Employer: _____ Relationship to Patient: _____

Office Use: Intake received by _____ New ❑ Update ❑ Entered by _____ Acct. # _____

2/2014

Responsible Guardians

First Name: _____ MI: _____ Last Name: _____

DOB: _____/_____/_____ Relationship to patient: _____

Marital Status: Single _____ Married _____ Partnered _____

Separated _____ Divorced _____ Widowed _____

Street Address: _____

Zip: _____ City: _____ State: _____

Phone: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

First Name: _____ MI: _____ Last Name: _____

DOB: _____/_____/_____ Relationship to patient: _____

Marital Status: Single _____ Married _____ Partnered _____

Separated _____ Divorced _____ Widowed _____

Street Address: _____

Zip: _____ City: _____ State: _____

Phone: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____