

Please present insurance card and photo ID for us to copy.

Baptist Primary Care

Date _____

Primary Care Physician _____

Person Responsible For Bill:

Guarantor Name: _____
 Street Address: _____
 City, State, Zip: _____
 Home Phone #: _____ Work Phone #: _____
 Relation to Patient: _____

Patient Information:

Name: _____
 Address: _____
 Home Phone #: _____ Work Phone #: _____
 Cell Phone #: _____
 Date of Birth: _____
 Sex: _____
 Marital Status: _____
 Social Security Number: _____
 (if a minor) Mother's Name: _____ Home Phone #: _____
 Father's Name: _____ Home Phone #: _____

Emergency Contact Information:

Contact Name: _____
 Relationship to Patient: _____
 Address: _____
 Home Phone #: _____ Work Phone #: _____

Primary Insurance Name:

Group #: _____ Policy #: _____
 Subscriber Name: _____
 Patient Relation to Subscriber: _____ Date of Birth: _____
 Social Security Number: _____
 Employer: _____ Work Phone #: _____

Secondary Insurance Name:

Group #: _____ Policy #: _____
 Subscriber Name: _____
 Patient Relation to Subscriber: _____ Date of Birth: _____
 Social Security Number: _____
 Employer: _____ Work Phone #: _____

Referred By: _____