

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: _____

