Chart #: ___________

For Office Use Only

Twin Springs Medical Center

PATIENT INFORMATION

Patient Name____Male ____Female____
First Name Middle Initial Last Name
Address _____________________________City _____________________ State ____ Zip ________
Date of Birth ___/___/_____ Social Security Number _____-_____-_______
Phone Numbers Home ______-_____-______Cell ____-_____-____ Work _____-_____-_____
Employer ____________________ Employer Number____-______-____

Pharmacy Name: ____________________ Location:____________________
Primary Care Physician:________________
Race: American Indian/Asian/African American/Native Hawaiian/White/other/unknown
Ethnicity: Hispanic/Latino/Not Hispanic/unknown **Language:** English or other_____________

How did you hear about the practice:____.

May we leave a message at your home with other residents? Yes No On your answering machine/voicemail? Yes No

_______I understand that a copy of the privacy policy (HIPAA) is available upon request.
_______I understand that if I no show for appointments I may be charged $25.00

SPOUSES/GUARDIAN INFORMATION

Name____ Cell Phone_____-_____-_____
First Name Middle Initial Last Name
Relationship to patient: Spouse/parent/legal guardian
Address:__________________________City:_____________________State:_______Zip:________
Date of Birth_____/_____/____ Social Security Number______-____-______
Employer's Name__________________________ Employer Number_____-______-______

PATIENT INSURANCE INFORAMTION

Please be aware that we are currently only contracted with Aultcare.
Do you have Insurance or are you self-pay? ______________________
Name of Primary Insurance Company _________________Name of Policy Holder_____________
Policy Number _______________________Group Number_________________
Secondary Insurance Company______________________ Name of Policy Holder_____________
Policy Number_______________________ Group Number_________________

EMERGENCY CONTACT

Nearest contact, not living with you

Name__________________________ Relationship to patient ______________________ Phone_____-_____-______

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT OR LEGAL GUARDIAN IS RESPONSIBLE FOR ALL FEES, REGARLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE BOOKKEEPER.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFOMRATION NECESSARY TO PROCESS CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO TWIN SPRINGS MEDICAL CENTER.

____ ______________________
SIGNATURE OF PATIENT OR AUTHORIZED PERSON DATE

For your convenience we do accept Visa and MasterCard, Credit or Debit