FIU HEALTH
FACULTY GROUP PRACTICE

Patient Demographic Information

Patient's Name:			Date:
SS#:	DOB:	Age:	Sex: F M
Home Address:		Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated	
City:	State:	Zip:	
Home Phone:	Work Phone:	Cell Phone:	
Email Address:		Referral Source:	
Emergency Contact:		Phone #:	Relationship:
Current Local Pharmacy Name		None ☐	Local Pharmacy Phone:
Mail-order Pharmacy:			
Employer Name:		Position:	
Primary Language:		Ethnicity ☐ Hispanic or Latino Origin ☐ Non-Hispanic	
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White			

REFERRING PHYSICIAN INFORMATION

Primary Care Physician's Name:	Phone #:

INSURANCE INFORMATION

Primary Insurance Co. Name:		Secondary Insurance Co. Name:	
Claim Address:		Claim Address:	
Policy #:	Group #:	Policy #:	Group #:
Subscriber's Name:	Relationship to Patient:	Subscriber's Name:	Relationship to Patient:
Subscriber's SS#:	Subscriber's DOB:	Subscriber's SS#:	Subscriber's DOB:
Employer's Name:	Employer's Phone#:	Employer's Name:	Employer's Phone#:

Sign below if you want to receive lab/diagnostic results and messages by U.S. and/or voice mail

_____

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GUARANTOR INFORMATION			
Guarantor Name:		Relationship to Patient:	
Guarantor Address:		Guarantor Phone:	
ACCIDENT INFORMATION (If Applicable)			
Automobile Accident		**Work Related Accident**	
Auto Accident: Yes _____ No _____	Date of Accident: ____/____/____	Worker's Comp Accident Yes _____ No _____	Date of Accident: ____/____/____
Auto Insurance Company Name:		Worker's Compensation Insurance Company:	
Claim Adjuster's Name and Phone#:		Claim Adjuster's Name and Phone #:	
Policy Holder's Name & Relationship to Patient:		Employer's Name at the Time of Accident:	
Policy #:	Claim #:	Claim #:	
Accident Information			
Where did the accident/injury occur:		Type of accident:	
Date:	Insurance Company:	Adjuster Name:	
Attorney Information:			
Attorney Name:		Address:	
Phone:			
WHO MAY WE THANK FOR REFERRING YOU TO THE PRACTICE?			
Name and Contact Information:			

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

Patient Name Printed _____/ Patient Signature: _____Date: _____

For completion when other than the patient signing or when a minor,

I _____am the parent, legal guardian, custodian or have Power of Attorney for this patient, for purpose of treatment, payment or health care operations.

Signature of Parent/ Legal Guardian/Custodian/Individual with Power of Attorney : _____
Printed Name of Signer: _____
Relationship to Patient: _____
Date: _____