BELLAIRE DOCTORS CLINIC

PATIENT INFORMATION

Name: _____ Patient ID#: _____ Sex: [ ] M [ ] F

Address: _____ Date of Birth: _____

City: _____State: _____ Zip: _____ Social Security #: _____

Home Phone: _____ Marital Status: [ ] Married [ ] Single

Work Phone: _____ Cell Phone: _____

Email Address: _____ Primary Care Physician:

PATIENT EMPLOYMENT **EMERGENCY CONTACTS (NAME & PHONE)**

[] Employed [] Retired []Not Employed (1)_____

Employer:_____ (2)_____

Phone: _____ (3) _____

RESPONSIBLE PARTY (Must complete if responsible party is other than the insured or patient.)

[ ] Same as Patient [ ] Same as Insured Relation to Patient:_____

Name: _____ Employer: _____

Address: _____ Phone: _____

City, State, & Zip: _____ Date of Birth: _____

Social Security#: _____

PRIMARY INSURANCE (Must complete in its entirety in order for us to file with your insurance.)

Name of Insured:_____ Relation to Patient: _____

Name of Insurance Company:_____ Insured SS#: _____

Insurance Phone #: _____ Policy Group #: _____

Insured Employer: _____ Insured Date of Birth: _____

******* IS THE PATIENT COVERED UNDER ANY OTHER INSURANCE? YES / NO***

(IF YES, PLEASE COMPLETE SECONDARY INSURANCE BELOW.)

SECONDARY INSURANCE (if applicable)

Name of Insured:_____ Relation to Patient: _____

Name of Insurance Company:_____ Insured SS#: _____

Insurance Phone #: _____ Policy Group #: _____

Insured Employer: _____ Insured Date of Birth: _____

I understand that this form must be completed in its entirety. I understand that if all of the above information is not completed, a claim may not be able to be filed to my insurance company; therefore, making me fully responsible for any charges incurred.

How did you hear about us?: ___family/friend ___doctor ___location ___yellow pages ___insurance ___internet ___other:

Patient/Responsibility Party Signature: _____