Family Care Network
We Take Care

Doctor: _____ Patient ID#_____

PATIENT INFORMATION

Name: _____ Nickname: _____
Address: _____ Sex: [ ]M [ ]F
_____ Date of Birth : _____Age:_____
City, State, Zip: _____ Social Security # _____
Primary phone: _____ Marital Status: _____
Secondary phone: _____
Employer: _____ **Email**_____
Occupation: _____ Internal use only – will not be sold outside FCN

List all immediate family members: _____

GUARANTOR (person signing the financial agreement)

[ ] Same as Patient
Name: _____ Phone: _____
Address: _____ Social Security # _____
_____ Employer: _____
City, State, Zip _____

EMERGENCY CONTACT #1

Name: _____
Address: _____
Phone: _____
Relationship to patient: _____

EMERGENCY CONTACT #2

Name: _____
Address: _____
Phone: _____
Relationship to patient: _____

PRIMARY INSURANCE

Insurance Company:_____ Patient Relationship to subscriber: _____
Subscriber's Name: _____ Insured ID: _____
Subscriber's Date of Birth: _____ Insured G#: _____
Subscriber's Phone # _____

SECONDARY INSURANCE

Insurance Company:_____ Patient Relationship to subscriber: _____
Subscriber's Name: _____ Insured ID: _____
Subscriber's Date of Birth: _____ Insured G#: _____
Subscriber's Phone # _____

If Secondary or Third insurance is Medicare, please fill out the Medicare Coordination of Benefits Questionnaire.

THIRD INSURANCE

Insurance Company:_____ Patient Relationship to subscriber: _____
Subscriber's Name: _____ Insured ID: _____
Subscriber's Date of Birth: _____ Insured G#: _____
Subscriber's Phone # _____

I verify that this address, phone and insurance is correct. I authorize my insurance benefits be paid directly to the health care provider. I am financially responsible for any balance due. I also authorize the health care provider or insurance company to release any information required for this claim. MEDICARE: I understand my provider agrees to accept the Medicare allowed charge as the full charge, and I am only responsible for the deductible, co-insurance and non-covered services.

Print Name: _____

Signature: _____ Date:_____
Parent or guardian if patient is a minor