Today's Date

Patient's Name ______________________________
First *Middle* *Last* *Maiden*

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other Race: ______________

Birth Date: ______________ Social Security # ______________ Sex: ❑ M ❑ F

Address ______________________________
Street *City* *State* *Zip Code*

Home Phone ______________ Work Phone ______________ Cell Phone ______________
Area Code *Area Code* *Area Code*

Patient's Employer Information

Name of Employer ______________ Status: ❑ Full-Time ❑ Part Time

Occupation ______________ Date of Employment ______________

Employer's Address ______________________________

Spouse Information

Name ______________ Date of Birth ______________

Social Security # ______________ Telephone ______________

Address ______________________________
Street *City* *State* *Zip Code*

If patient is under the age of 18 please complete

Father's Name ______________ Date of Birth ______________

Social Security # ______________ Marital Status ______________ Work Phone ______________

Address ______________ Home Phone ______________

Employer ______________________________

Mother's Name ______________ Date of Birth ______________

Social Security # ______________ Marital Status ______________ Work Phone ______________

Address ______________ Home Phone ______________

Employer ______________________________

Nearest Relative or Person to Notify in Case of an Emergency

Name ______________ Phone ______________

Address ______________________________

TOP OF LABEL
PATIENT LABEL MUST BE PLACED HERE
LABEL CANNOT BE IN ANY OTHER
LOCATION OR POSITION
BOTTOM OF LABEL

Insurance Form

Patient's Name ______________________________ DOB ________

Relationship to Policy Holder: *(Examples: Husband/Wife, Son/Daughter, Stepchild, Mother/Father)* ____________________

Primary Insurance

Name of Insurance Company ______________________________

Street Address, City, State, Zip ______________________________

Effective Date ________ Primary Care Physician ______________________________

Policy # ____________ Group # ____________ Pre-certification? ❑ Procedure ❑ Hospitalization

Policy Holder's Name ______________________________ MALE / FEMALE

Address ______________________________ Phone # ______________
Street City State Zip

Birth Date ______________________ Social Security # ______________

Policy Holder's Employer ______________________ Hire Date ________ Status ❑ PT ❑ FT

Address ______________________________ Phone # ______________
Street City State Zip

Please List Dependents Under this Coverage – Name, Date of Birth, Primary Care Physician

______________________________ ______________________________

______________________________ ______________________________

Patient's Name ______________________________

Relationship to Policy Holder: *(Examples: Husband/Wife, Son/Daughter, Stepchild, Mother/Father)* ____________________

Secondary Insurance

Name of Insurance Company ______________________________

Street Address, City, State, Zip ______________________________

Effective Date ________ Primary Care Physician ______________________________

Policy # ____________ Group # ____________ Pre-certification? ❑ Procedure ❑ Hospitalization

Policy Holder's Name ______________________________ MALE / FEMALE

Address ______________________________ Phone # ______________
Street City State Zip

Birth Date ______________________ Social Security # ______________

Policy Holder's Employer ______________________ Hire Date ________ Status ❑ PT ❑ FT

Address ______________________________ Phone # ______________
Street City State Zip

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS: I hereby authorize insurance and/or Medicare payments for services rendered to me, or my dependents, to be paid to Covenant Clinic. I hereby agree to pay Covenant Clinic any and all charges that exceed or that are not covered by my health insurance coverage. I also authorize Covenant Clinic to release all medical information necessary to process my claims.

Signed ______________________________ Date ____________ Time ________

❑ **Covenant Clinic Site** __________

Patient Information Page 2 of 2

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TOP OF LABEL
PATIENT LABEL MUST BE PLACED HERE
LABEL CANNOT BE IN ANY OTHER
LOCATION OR POSITION
BOTTOM OF LABEL