CHAFFEE FAMILY PHYSICIANS, P.C.

PATIENT NAME_____SOC SEC#:_____
DATE OF BIRTH: _____GENDER _____**DRUG ALLERGIES** _____
MARITAL STATUS _____PREFERRED LANGUAGE (circle one) English Spanish Other
RACE (circle one) AmericanIndian Asian Black/AfricanAmerican Hawaiian White Refused
ETHINICTY (circle one) Hispanic/Latino Non-Hispanic Refused

ADDRESS: _____CITY:_____ STATE:_____ZIP:_____
CELL PHONE: _____WORK:_____HOME:_____

EMAIL ADDRESS: _____

EMPLOYER: _____OCCUPATION:_____

EMERGENCY CONTACT NAME: _____PHONE #_____
RELATIONSHIP_____

INSURANCE INFORMATION

INSURANCE: _____
SUBSCRIBER: _____ID#_____

I agree to present a current INSURANCE card upon every visit and pay all co-payments, co-insurance and deductibles if applicable. I understand if I am unable to present a current insurance card, I agree to pay for all services rendered at the time of service.
I understand that accounts more than 90 days past due may be turned over to collection and any legal fees and/or costs of collections equal to 40% of the outstanding balance will be my responsibility. I authorize payment of medical benefits to the provider or supplier for these services and all future claims. I authorize the release of any information necessary to process this claim and all future claims.
I understand that should a claim be denied by insurance, I am liable for any charges incurred.

_____ _____
SIGNATURE PATIENT/GUARDIAN **DATE**