327 Stewart Road
Monroe, MI 48162

734-384-3660 phone
734-384-3661 fax

WELCOME TO OUR OFFICE

PATIENT'S NAME ____ **DATE OF BIRTH** _____/_____/________

SEX: M F **LAST 4 NUMBERS OF SOCIAL SECURITY NO:** _______________ **MARITAL STATUS: S M D W**

HOME#__________________________**WORK#**__________________________**CELL#**______________________

MAILING ADDRESS____
Number **Street** **Apt. #** **City** **State** **Zip Code**

EMAIL ADDRESS____

DRIVER'S LICENSE____
Issuing State **License Number**

I permit this office to handle any voicemail communication needed on my home#, cell# or work# as follows:

- ☐ Permitted to leave a detailed message on voicemail
- ☐ Permitted to leave callback number only on voicemail
- ☐ Do not leave any voicemail message

I DO permit this office to discuss my Private Health Information(PHI) with, to disclose my PHI to, and to contact in reference to me in an emergency the following individuals:

Spouse ____
Name **Telephone#**

Adult child ____
Name **Telephone#**

Adult child ____
Name **Telephone#**

My parent ____
Name **Telephone#**

My parent____
Name **Telephone#**

Other____
Name **Telephone#**

I DO NOT permit this office to discuss any of my Private Health Information with the following individual, however, I DO permit this office to contact in reference to me the following individual as my EMERGENCY CONTACT ONLY:

Emergency Contact Only____
Name **Telephone#**

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WELCOME TO OUR OFFICE – PAGE 2

Mail Order Pharmacy

Name ____ Telephone#______________________________

Address____

Local Pharmacy

Name ____Telephone#______________________________

Address____

INSURANCE INFORMATION:

PRIMARY:

Insurance Company
Name/Address:____

Subscriber's
Name: ____Date of Birth: ________/_______/_______Sex: M F

Last 4 numbers of
Subscriber's Social Security# _____________Patient's Relationship to Subscriber: Self____Spouse____Child____Other______

Contract Id# ________________________ Group# ____________________________ Co-pay Amount ______________

SECONDARY:

Insurance Company
Name/Address:____

Subscriber's
Name: ____Date of Birth: ________/_______/_______Sex: M F

Last 4 numbers of
Subscriber's Social Security# ____________ Patient's Relationship to Subscriber: Self____Spouse_____Child____Other____

Contract Id# ________________________ Group# ______________________ Co-pay Amount______________

SIGNATURE:

________ ____
Date **Signature**

If signed by patient's authorized representative, describe the representative's authority:

- ☐ Patient is a minor; I am the patient's parent and natural guardian.
- ☐ Patient is a minor; I am the patient's guardian, appointed by the _____________County Juvenile Court.
- ☐ Patient is a ward; I am the patient's guardian, appointed by the _____________County Probate Court.
- ☐ I am the patient's attorney in fact, as designated in the patient's Durable Power of Attorney for Health Care.
- ☐ Other (describe) ____