

# THE NEIGHBORHOOD DOCTOR

(ALL INFORMATION REQUIRED AND MUST BE UPDATED EVERY 6 MONTHS)

DATE: \_\_\_\_\_

PATIENTS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

HOME NUMBER: \_\_\_\_\_ CELL NUMBER: \_\_\_\_\_

BEST NUMBER TO BE REACHED AT? HOME \_\_\_\_\_ CELL \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_ SINGLE: \_\_\_\_\_ MARRIED: \_\_\_\_\_ RACE: \_\_\_\_\_

WHO IS RESPONSIBLE FOR PAYMENT: \_\_\_\_\_

## INSURANCE INFORMATION

INSURANCE COMPANY: \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

SUBSCRIBER/MEMBER NUMBER: \_\_\_\_\_

GROUP/ACCOUNT NUMBER: \_\_\_\_\_

PRIMARY POLICY HOLDER NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

RELATIONSHIP TO PATIENT: SELF \_\_\_\_\_ PARENT \_\_\_\_\_ SPOUSE \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Neighborhood Doctor or insurance company to release any information required to process my claims.

\_\_\_\_\_  
*Patient/Guardian signature*

\_\_\_\_\_  
*Date*