UTFP Patient Profile

Patient Information

Full Name: ____________________ DATE OF BIRTH: ____________________

Address: ____________________Apt#__________ City ____________________St __________Zip___________

SOCIAL SECURITY #: ____________________ [ ] Male [ ] Female MARITAL STATUS: [ ] MARRIED [ ] SINGLE [ ] DIVORCED

Ethnicity: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino Race__________________

PHONE: (__) ___ ____________________ [ ] HOME [ ] CELL [ ] OTHER PHONE:(___) ___ ____________________ [ ] HOME [ ]CELL [ ]OTHER

EMAIL ADDRESS: ____________________

Preferred Method of Contact: ______Email _____ Cell Phone _____Home Phone _____ Work Phone _____ Letter

PHARMACY: ____________________ PHARMACY PHONE: (_)____________________

EMERGENCY CONTACTS

NAME:____________________PHONE: ( ) ____________________RELATIONSHIP____________________

NAME:____________________PHONE: ( ) ____________________RELATIONSHIP____________________

PATIENT EMPLOYMENT

[ ] EMPLOYED [ ] RETIRED [ ] UNEMPLOYED [ ] OTHER

EMPLOYER: ____________________PHONE: (_____)____________________

PERSON RESPONSIBLE FOR BILL RELATIONSHIP TO PATIENT: [ ] SELF [ ] SPOUSE [ ] PARENT [ ] OTHER

NAME: ____________________ EMPLOYER: ____________________

ADDRESS: ____________________ PHONE: (____)____________________

CITY/STATE/ZIP: ____________________ DATE OF BIRTH:____________________

PHONE: ( )____________________SOCIAL SECURITY #:____________________

INSURANCE INFORMATION: PLEASE BRING ALL INSURANCE CARDS FOR SCANNING TO OUR SYSTEM AND PROPER INSURANCE FILING

PRIMARY INSURANCE: ____________________ INSURED ID# ____________________ GROUP____________________

SUBSCRIBERS NAME: ____________________ RELATIONSHIP TO PATIENT: [ ] SELF [ ] SPOUSE [ ] PARENT

SOCIAL SECURITY #: ____________________ DATE OF BIRTH __________________ Copay_____________

SECONDARY INSURANCE: ____________________ INSURED ID#____________________ GROUP____________________

SUBSCRIBERS NAME: ____________________ RELATIONSHIP TO PATIENT: [ ] SELF [ ] SPOUSE [ ] PARENT

SOCIAL SECURITY #: ____________________ DATE OF BIRTH ___________________ Copay_____________

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.

Patient/Guardian Signature Date