Bluffton-Okatie Primary Care

Patient Information Form

____

Patient's Full Name

____

Home Phone # **Cell Phone #** **Alternate Phone #**

____

Address **Apt#** **Email Address**

____

City **State** **Zip**

____

Patient's Social Security **Patient's Date of Birth**

____

Policy Holder's Name **Policy Holder's SS #** **Policy Holder's Date of Birth**

____

In Case of Emergency Contact **Relationship** **Phone Number**

____

*__Race__ ***Language of Preference** ***Ethnicity**

***For Demographic Purpose Only**

Insurance Authorization and Assignment

I authorize Bluffton-Okatie Primary Care to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Bluffton-Okatie Primary Care. I understand that I am ultimately responsible for all the services whether covered by insurance or not. I also authorize my physician; based on his/her discretion to access my chart for utilization management.

______________________ ______________________

Date **Signature**