PATIENT INFORMATION:

Name: Last_____ First_____ Middle_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Social Security Number_____ Email _____

Employer_____ Occupation_____

Employer's Address_____

Home Phone Number_____ Work Phone Number_____ Email_____

Race: □ White □ Black □ Other **Sex:** □ Male □ Female **Language:** □ English □ Spanish □ Other

Marital Status: □ Married □ Single □ Separated □ Divorced □ Widowed □ Other

RESPONSIBLE PARTY INFORMATION: (If Not Above)

Name: Last_____ First_____ Middle_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Social Security Number_____

Employer_____ Occupation_____

Employer's Address_____

Home Phone Number_____ Work Phone Number_____ Other_____

Race: □ White □ Black □ Other **Sex:** □ Male □ Female **Language:** □ English □ Spanish □ Other

Marital Status: □ Married □ Single □ Separated □ Divorced □ Widowed □ Other

Patient's Relationship to Responsible Party: ***(Please check appropriate box)***

□ Self-18 □ Spouse-01 □ Mother-32 □ Father-33 □ Child-19 □ Adopted Child-09 □ Foster Child-10 □ Dependent-23

□ Stepson/Stepdaughter-17 □ Handicapped Dependent-22 □ Emancipated Minor-36 □ Dependent of Minor Dependent-24

□ Niece/Nephew-07 □ Grandparent-04 □ Grandson/Granddaughter-05 □ Ward-15 □ Significant Other-29 □ Life Partner-53

□ Other Adult-34 □ Employee-20 □ Injured Plaintiff-41 □ Other-G8 □ Child where insured has no financial responsibility-43

Is this Visit Related To:

- Industrial Were You Injured on The Job? □ Yes □ No Date of Injury_____ Industrial Claim #_____
- Accident Was an Automobile Involved? □ Yes □ No Date of Accident_____ Attorney Name_____
- Other □ Yes □ No Date of Accident_____ Attorney Name_____

IN CASE OF EMERGENCY CONTACT:

Name_____ Relationship To Patient_____

Address:_____ Phone Number_____

Nearest Relative Not Living In Household_____ Phone Number_____

(PLEASE COMPLETE THE INSURANCE INFORMATION ON THE BACKSIDE OF THIS FORM BEFORE SIGNING)

I, _____, certify that the completed information is correct and I received the Notice of Privacy Practice Form on ____/____/____.

CAPE FEAR VALLEY HEALTH | CAPEable of EXCEPTIONAL HEALTHCARE without EXCEPTION

Patient Name:_____

DOB: _____

NEW PATIENT INFORMATION

INSURANCE INFORMATION:

Primary Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Social Security Number: _____ Subscriber's Sex: □ Male □ Female

Subscriber's Relationship to **Responsible Party:** □ Self-1 □ Spouse-2 □ Other-0

Secondary Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Social Security Number: _____ Subscriber's Sex: □ Male □ Female

Subscriber's Relationship to **Responsible Party:** □ Self-1 □ Spouse-2 □ Other-0

Tertiary (Third) Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Social Security Number: _____ Subscriber's Sex: □ Male □ Female

Subscriber's Relationship to **Responsible Party:** □ Self-1 □ Spouse-2 □ Other-0