

# Center for Family Medicine

701 E. Rosser Ave., Bismarck, ND 58501

## Office Use Only

Account #: \_\_\_\_\_

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First M.I. Suffix

Address \_\_\_\_\_ Apt # \_\_\_\_\_ Birth Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Marital Status S M D W O

City / St. / Zip \_\_\_\_\_ Phone: Work ( ) \_\_\_\_\_ Ext. \_\_\_\_\_  
Home ( ) \_\_\_\_\_

Gender Male / Female Ethnicity \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
Email \_\_\_\_\_

Language Spoken \_\_\_\_\_ Do you use tobacco products Y / N

## Parent/Guardian/Responsible Party (If different from above)

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First M.I. Suffix Birth Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ Marital Status S M D W O

City / St. / Zip \_\_\_\_\_ Phone: Work ( ) \_\_\_\_\_ Ext. \_\_\_\_\_  
Home ( ) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Gender Male / Female Email \_\_\_\_\_

## Insurance Information

### Primary Insurance Coverage:

\*Policy Holder: \_\_\_\_\_

\*Birth Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\*Relationship to patient \_\_\_\_\_

Name of Insurance Co.: \_\_\_\_\_

Address: \_\_\_\_\_

Policy No.: \_\_\_\_\_

Group No.: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Copay. Amt. \_\_\_\_\_

### Secondary Insurance Coverage:

\*Policy Holder: \_\_\_\_\_

\*Birth Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\*Relationship to patient \_\_\_\_\_

Name of Insurance Co.: \_\_\_\_\_

Address: \_\_\_\_\_

Policy No.: \_\_\_\_\_

Group No.: \_\_\_\_\_

Effective Date: \_\_\_\_\_

## OTHER CONTACTS to include emergency, financial and other services

Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Address \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

City / St. / Zip \_\_\_\_\_