

Arbor Place Family Medicine, P.C.
DR. Thomas Varughese

PATIENT INFORMATION

Preferred Name to be Called _____

Last Name _____ First _____ Middle Initial _____

SSN _____ DOB _____ Sex Male Female

Marital Status Single Married Divorced Widowed Occupation _____

Home Address _____

Telephone _____ Cell Phone _____ Email _____

May we leave voicemails at the above telephone numbers? Voice Yes No / Cell Yes No

May we send you emails (i.e., appointment reminders, product and service offerings)? Yes No

Nearest friend/relative not living with you _____

Relationship to patient _____ Telephone _____

WHERE DID YOU HEAR ABOUT US? (Circle one or more)

Referring physician _____ Telephone _____

Physician ER Friend/Patient Yellow Pages Advertisement Website Other

INSURANCE INFORMATION

Primary Insurance Co. _____ Address _____

Subscriber Name _____ SSN _____

DOB _____ Policy Identification Number _____

Group Identification Number _____ Subscriber relation to Patient _____

Employer _____ Phone _____ Deductible _____ Co-Pay _____

Secondary Insurance Co. _____ Address _____

Subscriber Name _____ SSN _____

DOB _____ Policy Identification Number _____

Group Identification Number _____ Subscriber relation to Patient _____

Employer _____ Phone _____ Deductible _____ Co-Pay _____

PRIVACY PRACTICES

I, _____, have received a copy of **Arbor Place Family Medicine, P.C.**, Notice of Privacy Practices.

Signature of Patient/Guardian _____ Date _____

PAYMENT AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED benefits be made to **Arbor Place Family Medicine, P.C.** I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, and its agents, any information needed to determine these benefits or the benefits payable to related services.

Signature of Patient/Guardian _____ Date _____

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to **Arbor Place Family Medicine, P.C.** by any insurance policy, self-insurance program or other benefit.

CLINICAL INFORMATION

Please list any:

Allergies:

Current Medications:
