CAPE FEAR VALLEY HEALTH | HARNETT HEALTH

Physician Office Practices

Patient Information

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____ State _____ Zip Code: _____

Home Phone Number: _____ Cell Number: _____

Emergency Contact: _____ Phone Number: _____ Relation: _____

Race: ☐ White ☐Black ☐ Asian ☐ Hispanic ☐ Pi/Hawaii ☐ American/Indian ☐ Pt Decline ☐ Other Sex: ☐ Male ☐Female

Language: ☐ English ☐ Spanish ☐ Other: _____

RESPONSIBLE PARTY INFORMATION: (If not above)

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Social Security Number: _____ Email: _____

Address: _____ City: _____ State _____ Zip Code: _____

Employer: _____ Occupation: _____ Work Phone Number: _____

Employer Address: _____ City: _____ State _____ Zip Code: _____

Home Phone Number: _____ Cell Number: _____

Race: ☐ White ☐Black ☐ Asian ☐ Hispanic ☐ Pi/Hawaii ☐ American/Indian ☐ Pt Decline ☐ Other Sex: ☐ Male ☐Female

Language: ☐ English ☐ Spanish ☐ Other: _____

Marital Status: ☐Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Patients Relationship to Responsible Party: ☐ Self-18 ☐ Child

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 AN EMERGENCY CONTACT:

Name: _____ Relationship To Patient: _____ Phone Number: _____

Address: _____ City: _____ State _____ Zip Code: _____

Nearest Relative Not Living in the Household: _____ Phone Number: _____

(PLEASE COMPLETE THE INSURANCE INFORMATION ON PAGE 2 OF THIS FORM)

INSURANCE INFORMATION:

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

Subscriber's Name: _____ Subscribers date of birth: _____

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

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: _____ Subscribers date of birth: _____

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

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: _____ Subscribers date of birth: _____

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

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

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

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