ADVANCED PACIFIC

PATIENT INTAKE FORM

Account #: ____________________ Date: ____________________

Patient Name: ____________________ DOB: ____________________ Gender: ☐ Male ☐ Female

Street Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Mailing Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Social Security #: ____________________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________ Ext: __________

Employer: ____________________ Occupation: ____________________ Address: ____________________

If Minor, Name of Parents:

Parent 1: ____________________ Parent 2: ____________________

Guardian: ____________________

If married, spouse's name: ____________________ Employer: ____________________ Occupation: ____________________

Are you a student? ☐ Yes ☐ No ☐ Full-time ☐ Part-time Name of School: ____________________

Referring Doctor: ____________________ Primary Care Physician: ____________________

Responsible Party Information

Name: ____________________ Relationship to Patient: ____________________ Social Security #: ____________________

Street Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________ Ext: __________

Employer: ____________________ Occupation: ____________________ Address: ____________________

Medical Insurance Information

Primary Insurance: ____________________ Group #: ____________________ Coverage Code: ____________________

Subscriber Name: ____________________ Date of Birth: ____________________ Social Security #: ____________________ Employer: ____________________

Secondary Insurance: ____________________ Group #: ____________________

Subscriber Name: ____________________ Date of Birth: ____________________ Social Security #: ____________________ Employer: ____________________

Is this a work-related injury? ☐ Yes ☐ No

Please remember that insurance is considered a method of reimbursing the doctor. Some companies pay fixed amounts for certain procedures, and others pay a percentage of the charges. It is your responsibility to pay any deductible, copay or any other balance not paid by your insurance company.

After 90 days or three statements sent to the address on file, any unpaid balance will incur a 2% interest rate per month until the balance has been paid in full. The account will be placed on a “bad debt” status or sent to collections.

All past due accounts will require a $200 deposit before any future appointments will be scheduled.

Signature of Responsible Party: ____ Date: ______________