NWABUEZE
PRIMARY CARE CLINICS

PATIENT INFORMATION

(Please PRINT)

FIRST NAME _____ **MI** _____ **MAIDEN NAME** _____**LAST NAME** _____ **SUFFIX**_____

DOB _____SSN _____ **DRIVER'S LICENCE NO** _____

GENDER □ M □ F MARITAL STATUS □ Single □ Married □ Divorce □ Separated

RACE: □ American Indian □ Asian □ Black/African American □ White □ Other □ Decline to Specify

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino □ Decline to Specify

MAILING ADDRESS _____ APT/LOT NO _____

PHYSICAL ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PH _____ CELL PH _____ WORK PH _____ EXT _____E-MAIL ADDRESS _____

PREFERRED CONTACT METHOD □ HOME PHONE □ CELL PHONE □ WORK PHONE □ MAIL □ E-MAIL

PREFERRED PHARMACY_____ ADDRESS OF PHARMACY_____

EMERGENCY CONTACT : 1) _____ PH _____ Permission to Discuss Health _____
Yes N0

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Yes N0

INSURANCE:

PRIMARY INSURANCE POLICY HOLDER _____ **RELATIONSHIP TO PATIENT** _____
(*Please write name as it appears on insurance card)*
GENDER □ M □ F TEL:_____SSN _____ DOB _____

MAILING ADDRESS _____CITY _____ STATE _____ZIP _____

COMPANY_____GROUP#_____POLICY#_____EMPLOYER_____

ADDITIONAL INSURANCE POLICY HOLDER _____ **RELATIONSHIP TO PATIENT** _____
(*Please write name as it appears on insurance card)*
GENDER □ M □ F TEL:_____SSN _____ DOB _____

MAILING ADDRESS _____CITY _____ STATE _____ZIP _____

COMPANY_____GROUP#_____POLICY#_____EMPLOYER_____

GUARANTOR: (PARENT INFORMATION OR PERSON RESPONSIBLE FOR PAYMENT)

NAME _____ **RELATIONSHIP TO PATIENT** _____

MAILING ADDRESS _____ CITY _____STATE _____ ZIP_____

DRIVER'S LICENCE NO _____

X _____ **PRINT NAME**_____ **DATE**_____
SIGNATURE OF GUARANTOR

AUTHORIZATION & RELEASE

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS BE MADE TO NWABUEZE NNAMDI INC DBA EAST FELICIANA PRIMARY CARE CLINIC ON MY BEHALF. I ALSO THE AUTHORIZE RELEASE OF ANY INFORMATION CONCERMING MYSELF OR DEPENDENT'S HEALTH CARE, ADVICE AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS AS WELL AS FOR REFERRAL PURPOSES.

X _____ **DATE** _____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF MINOR)