Twin Lakes Medical Foundation, Inc

IS THIS VISIT DUE TO A MOTOR VEHICLE ACCIDENT OR INJURY ON THE JOB? YES NO
IF YES, DATE OF ACCIDENT OR INJURY ON THE JOB: _____
IS THE PATIENT ENTITLED TO BENEFITS THROUGH THE DEPT. OF VETERANS AFFAIRS? YES NO
IF YES, HAS THE DVA AUTHORIZED AND AGREED TO PAY FOR CARE AT THIS FACILITY? YES NO

PATIENT INFORMATION

SSN: _____

Last Name: _____ **First Name:** _____ Middle: _____

Mailing Address: _____

_____

City: _____ State: _____ Zip: _____

Phone number(s): Please check the Primary number where you can be reached

☐ Home: (_____) _____--_____

☐ Work: (_____) _____--_____

☐ Cell: (_____) _____--_____

Sex: M F **Birth Date:** _____ Employer: _____**E-Mail Address:**_____

Who is your Usual Provider: (Please Print Clearly) _____

If you have a referring doctor please print clearly in the space provided: _____

Marital Status: Divorce Married Separated Single Widowed Other

Employment Status: Full Time Part Time Not employed Self employed Retired Military duty

Student: Full Time Part Time Not a student

Relationship to responsible party for the bill: _____

ADDITIONAL PATIENT INFORMATION

Maiden Name:_____

Primary Custodial Parent: _____

Race: White Black/African American Asian Native Hawaiian American Indian/Alaskian Native

Ethnicity: Not Hispanic Hispanic/Latino Unreported/refused to report

Primary Language:_____

FINANCIALLY RESPONSIBLE PARTY

Last Name: _____ **First Name:** _____ Middle: _____

Mailing Address: _____

_____

City: _____ State: _____ Zip: _____

Phone number(s) Home: (_____) _____--_____

Work: (_____) _____--_____

Cell: (_____) _____--_____

Sex: M F **Birth Date:** _____ SSN: _____Employer: _____

E-Mail Address:_____ **Relationship to the patient:** _____

EMERGENCY CONTACT

Last Name	First Name	MI
Address:		
City	ST	Zip
Home Phone:	Work Phone:	Cell Phone:
Relationship to the patient:		

ADDITIONAL CONTACT INFORMATION

Last Name	First Name	MI
Address:		
City	ST	Zip
Home Phone:	Work Phone:	Cell Phone:
Relationship to the patient:		

POLICY INFORMATON

Please present your insurance cards and co-pays are due at the time of visit.

Primary Policy Holder: _____ Birth Date: _____

Effective Date:_____ Expiration Date: _____

Policy Holder's relationship to the patient: _____

Secondary Policy Holder: _____ Birth Date: _____

Effective Date: _____ Expiration Date: _____

Policy Holder's relationship to the patient: _____

_____ _____

Patient Signature **Date**

_____ _____

Guardian or Power of Attorney Signature **Date**