Jefferson Street Family Practice

If you have insurance JSFP is contracted with, and you want JSFP to file, please complete all information and please furnish a current insurance card.

Section 1: ____ ____/____/____ Sex___
Name (last, first, middle initial) Date of birth

____ Home Tel # ________________
Street Address City/State Zip

Social Security # _______-_____-_______ Work Tel # _________________ Cell # _________________

Patient Status: □ Minor Child (Go to Section 2) □ Married □ Single □ Other

Employed: □ Yes □ No Student: □ Full Time □ Part Time

Employer Name: ______________________________ Job Title: ____________________________

Section 2: Do you have insurance? □ No, I am self pay □ Yes (complete this section)

_______________________________________ _______________________________
Name of Employer Name of Insurance

________________________ _______________________ ______________________
Identification # Group # Customer Service #

____ ____/____/____ Sex___
Name of Policy Holder (last, first, MI) Date of birth

____ Home Tel # ________________
Street Address City/State Zip

Social Security # _______-_____-_______ Work Tel # _____________ Cell # _________________

Patient's Relationship to Policy Holder: □ Self □ Spouse □ Child □ Other

Section 3: Person to contact in case of emergency: ______________________________

Relationship: ________________________________ Telephone #: _______________________

Address: ____
Street Address City/State Zip Code

Is patient allergic to any medications? If yes, please list medications:

Please list name, birth date and relationship of any household members: (Check those who are patients at JSFP)

Full Name Sex DOB Relationship Full Name Sex DOB Relationship

□____ □____

□____ □____

□____ □____

If you have SECONDARY INSURANCE, PLEASE PRINT THE NEXT FORM

PLEASE READ, SIGN AND DATE: I understand payment is due at the time of service, unless covered by a JSFP contract health insurance plan, in which case I understand I will pay my share and authorize payment of medical benefits to the physician who accepts assignment. I also understand that if a service is not a benefit of my plan, I am responsible and will pay promptly or make arrangements to pay. I UNDERSTAND THAT LAB TESTS ARE DONE BY A SEPARATE FACILITY AND I MAY RECEIVE SEPARATE BILLING. I authorize release of medical records or other information, including results of any lab tests, on order to process a claim. By placing my signature below, I am consenting to treatment by the practitioners and staff of Jefferson Street Family Practice.

____ ____________________
Signature/Relationship to Patient Date