Rindfleisch Family Practice

Patient Information

Date:_____

Patient Name: _____ **DOB**: _____

Address: _____ **Home Phone**: _____

_____ **Cell Phone**: _____

E-Mail:_____ **SSN**: _____

Pharmacy (please indicate which location) _____

Place of Employment: _____ **Work Phone**: _____

May we contact you at you work place (circle): Yes No

Marital Status (circle): S M W D **Sex** (circle) M F **Student** (circle) Yes No

Race: _____American Indian or Alaskan Native _____Asian _____African American _____White

_____Pacific Islander _____Refuse

Ethnicity: _____Hispanic _____Non-Hispanic or Latino _____Refuse

Language spoken: _____

How did you hear about our office? _____

Emergency Contact

Name:_____ Phone: _____

Address:_____

Email:_____ Relation: _____

Responsible Party (if different from Patient)

Name:_____ Phone: _____

Address:_____ Relation:_____

Insurance Information

Medical Insurance: None Aetna Anthem BC/BS Cigna Medicare Other: _____

Name of Policyholder: _____ ID Number: _____

If you are not the policyholder, please fill out below: Group Number:_____

Relationship: _____ Date of Birth: _____ SSN: _____

Employer: Work Phone: