

# WELCOME TO ADVANCED MEDICAL CARE

## PATIENT INFORMATION

1. Patient Name		12. Married	Single	Other
2. Address		13. Part Time Student      Full Time Student		
3. City, State		Unemployed      Employed		
4. Zip Code		Retired      Other		
5. Telephone No		14 Referring Physician		
5a. Cell Phone No		15. If not referred by a physician, who referred you:  Friend Name  Newspaper  Radio  Community Event  Yellow Pages  Web Page  Other		
5b. Email Address				
6. Previous Physician				
7. Social Security No.				
8. Employer Name				
8a. Employer Address				
8b. City, State, Zip		16. Who is financially responsible for the bill		
9. Employer Phone No.		Self      Father      Child		
10. Patient Sex		Spouse      Mother      Other		
11. Birthdate				

## FINANCIALLY RESPONSIBLE PERSON (If different than above)

1. Financially Responsible Person (Name)		6. Employer Name	
2. Address		7. Employer Address	
3. City, State, Zip		7a. City, State, Zip	
4. Zip Code		8. Employer Phone No.	
5. Telephone No.		9. Social Security No.	
12. Other Address (Seasonal)		10. Birthdate	11. Sex

## INSURANCE COMPANY INFORMATION

1. Primary Insurance Company Name			5. Address	
2. Holder of Policy	2a. Date of Birth	2b. Social Security No.	5a. City, State, Zip	
3. Policy No.		4. Group No.	5b. Telephone No.	
1. Secondary Insurance Company Name			5. Address	
2. Holder of Policy	2a. Date of Birth	2b. Social Security No.	5a. City, State, Zip	
3. Policy No.		4. Group No.	5b. Telephone No.	