HARVARD
Family Physicians, P.C.
Family Medicine OB/GYN Pediatrics Pharmacy

Patient Information

Date:_____ How did you hear about us?_____

Last Name:_____ First Name:_____

Social Security #:_____ Date of Birth:_____ Gender: ☐ M ☐ F

Marital Status: Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐ Race:_____

Address:_____ City:_____ State_____ Zip:_____

Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( )_____

Employer:_____ Occupation:_____

E-Mail Address:_____ Pharmacy and Location:_____

Primary Insurance Information: *(Required Information)*

Policy Holder Name:_____ Policy Holder SS#:_____

Policy Holder Date of Birth:_____ Policy Holder Employer:_____

Policy Holder Insurance Company:_____

Secondary Insurance Information: *(Required Information)*

Policy Holder Name:_____ Policy Holder SS#:_____

Policy Holder Insurance Company:_____ Policy Holder Employer:_____

Spouse's and/or Responsible Party Information: *(Required Information)*

Name:_____ Social Security #:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Cell Phone: ( )_____

In Case of Emergency Please Contact: *(Required Information)*

Contact Name:_____ Contact Number:( )_____ Relationship:_____

Nearest Relative Other Than Spouse:_____ Phone Number: ( )_____

Do You Have A Living Will? ☐ **Y** ☐ **N**

Do You Have An Advanced Medical Directive? ☐ **Y** ☐ **N**

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services and rendered or to be rendered, without obtaining my signature on each and every claim. I will be bound by this signature as thought the undersigned had personally signed the particular claim for me or my dependents.

I hereby authorize the above insurance(s) to pay and hereby assign directly to Harvard Family Physicians, P.C. all benefits, if any, otherwise payable to me for his/her service as described on the attached forms. I understand I am financially responsible for all changed incurred. I further acknowledge that any insurance benefits, when received by and paid to Harvard Family Physicians will be credited to my account, in accordance with the above assignments.

_____ _____

Authorized Signature of Policy Holder Patient's Signature Date