FAMILY DOC'S CLINIC

BOARD CERTIFIED IN FAMILY PRACTICE
E. JAMES DAROS, D.O ANTONY DAROS, D.O. KELLY TREADWAY, DNP, RN, AGNP-C
8275 HOLLY RD., SUITE 1 GRAND BLANC, MI 48439
PH: 810-603-0990 FAX: 810-603-1678

PATIENT INFORMATION

Today's Date: _____ **SS#:** _____-_____-_____

Patient Name: _____ **Birth Date:** _______________

Sex: M___ F___ Marital Status: Never Been Married____ Married____ Divorced ____

Domestic Partner____ Widow____

Sexual Orientation: Male___ Female___ Circle One: L G B T

Previous/Maiden Name(s):_____ Spouse's Name: _____

If Minor, Custodial Parents/Guardians Name(s): _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Is Billing Address the Same as Home Address?-Yes___ No___ If no, enter below

Billing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ **Cell Phone:** ( ) _____-_____

Work Phone: ( ) _____-_____ Ext. _____

Email: _____

Contact Preference: Mail___ Home Phone___ Cell Phone___ Work Phone___

Employed___ Unemployed___ Retired___ Disabled ___ F-T Student___ P-T Student___

Employer: _____

Ethnicity:
Hispanic or Latino___
Not Hispanic or Latino___
Prefer Not to Answer___

Race:
American Indian or Alaska Native___
Native Hawaiian or Other Pacific Islander___
White or Caucasian___
Black or African American ___
Other Race___
Prefer Not to Answer___

Language/Communication Preference if not English: _____

MEDICAL INFORMATION IN CASE OF EMERGENCY

CONTACT Name: _____

Phone: ( ) _____-_____ Relationship to Patient: _____

CONTACT Name: _____

Phone: ( ) _____-_____ Relationship to Patient: _____

PREFERRED PHARMACY

Local Pharmacy Name: _____ Phone: _____

Mail Order Pharmacy Name: _____ Phone: _____

FIRST INSURANCE INFORMATION

Card Holder's Information:

Name: _____ Birth Date: _______________

SS#: _____-_____-_____ Sex: M___ F___ Relationship to Patient: _____

Employer: _____ Name of Insurance: _____

SECONDARY INSURANCE INFORMATION

Card Holder's Information:

Name: _____ Birth Date: _______________

SS#: _____-_____-_____ Sex: M___ F___ Relationship to Patient: _____

Employer: _____ Name of Insurance: _____

THIRD INSURANCE INFORMATION

Card Holder's Information:

Name: _____ Birth Date: _______________

SS#: _____-_____-_____ Sex: M___ F___ Relationship to Patient: _____

Employer: _____ Name of Insurance: _____

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policy, payment is expected at the time services are rendered. Knowledge of insurance deductibles and co-payments are the patient's responsibility. **You will be responsible for your part of the charges at each visit, unless arrangements are made in advance. We accept cash, check, American Express, Discover, MasterCard, and Visa for your convenience.** Your signature below indicates that you understand and accept this policy.

_____ _____

Signature of Patient or Legal Guardian Date