NORTHEAST IOWA FAMILY PRACTICE CENTER
2055 KIMBALL AVENUE SUITE 101
WATERLOO, IOWA 50702-5047 (319)272-2112

** *ADULT PATIENT INFORMATION (18 YEARS OF AGE AND OLDER)* **

How did you hear about us? Internet☐ Friend/Relative☐ Hospital ☐ Insurance Carrier ☐ Newspaper ☐ Patient in the Practice☐ Physician☐ Radio☐ Social Media☐ Television☐ Website☐ White Pages☐ Word of mouth☐ Yellow Pages ☐
Other☐ Please Explain:_____

Today's Date:_____

Legal Name: (first, middle, last)_____ **Male/Female**
(Circle one)

Preferred Name: _____ **Maiden Name:** (if applicable)_____

Birth Date: (MM/DD/YYYY)_____ **Social Security Number:** _____

Home Address:_____ **Apt/Lot #**_____

City/State/Zip:_____

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

Consent to text: Yes/No (Circle one) **Contact Preference:** Home Phone/Work Phone/Mobile Phone/Mail (Circle one)

Consent to call: Yes/No (Circle one) **Authorize to obtain Medication History:** Yes/No (Circle one)

Your Email Address:_____

Do You Want Access to Your Own Online Chart? ☐ **Yes** ☐ **No** ☐ **Have no Email Address**

Marital Status: Single/Married/Divorced/Widowed/Other (Circle one)

Language preference: _____ **Race:** _____ **Ethnicity:** Non-Hispanic/Hispanic (Circle one)

Preferred Pharmacy: _____

Person to contact in case of an Emergency:_____

Relationship:_____ **Phone Number: ( )**_____

Next of Kin: (first, middle, last)_____

Relationship: _____ **Phone Number: ( )**_____

Employer:_____

May we contact you at work? *YES NO* (Circle one) **If yes, Employer Phone No: ( )**_____

Occupation: _____

INSURANCE INFORMATION ON BACK

Primary Insurance Carrier: _____

Subscriber's (Policy Holder) **Legal Name**:_____

Subscriber's Date of Birth: _____ Subscriber's Social Security Number: _____
(MM/DD/YYYY)

Policy Number:_____

Group Number:_____ Effective Date(MM/DD/YY):_____ Issued through employer? Yes ☐ No☐

Subscriber's Employer _____

Subscriber's Address _____

Is this a family policy? Yes☐ No☐ If yes, who does it cover?_____

Secondary Insurance Carrier: _____

Subscriber's (Policy Holder) **Legal Name**:_____

Subscriber's Date of Birth**:** _____ Subscriber's Social Security Number _____
(MM/DD/YYYY)

Policy Number:_____

Group Number:_____ Effective Date(MM/DD/YY):_____ Issued through employer? Yes ☐ No☐

Subscriber's Employer _____

Subscriber's Address _____

Is this a family policy? Yes☐ No☐ If yes, who does it cover?_____

*****FILL OUT THE SECTION BELOW ONLY IF THE BILL IS TO BE SENT TO A DIFFERENT ADDRESS*****

Relationship: Father☐ Mother☐ Stepfather☐ Stepmother☐ Guardian☐ Other☐

Name (first/middle/last):_____

Address:_____

City/State/Zip:_____

May we contact the above named? Yes ☐ No☐ If yes, phone numbers: Home ( ) _____

Other ( ) _____

Assignment of Benefits/Release of Information

I, the undersigned assign directly to the Northeast Iowa Family Practice Center all medical benefits, if any, otherwise payable to me by my insurance company for services rendered. I understand that I am financially responsible for all charges whether paid or not by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. My signature will be considered valid for a lifetime. This authorization applies to all services until the statement is revoked by me.

Signature of Insured/Guardian:_____ **Date:**_____