



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

*******PATIENT INFORMATION FOR UNDER 18 YEARS OF AGE*****

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: _____

Patient's Full Legal Name (first/middle/last): _____ Male/Female
(circle one)

Preferred Name: _____

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

Home Address: _____

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

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

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

Preferred Pharmacy: _____

*******THE SECTION BELOW IS REGARDING WHO THE PATIENT LIVES WITH*******

Relationship: **Father** **Stepfather** **Mother** **Stepmother** **Guardian**

Name (first/middle/last): _____

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

Employer's Name: _____

Employer's Address: _____

City/State/Zip: _____

May we contact at work? Yes No If yes, Employer Phone Number: () _____

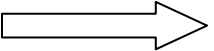
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Emergency Contact Information

Person to contact in case of an emergency, other than parents:

Phone Number: () _____ Relationship: _____

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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/YYYY): _____ Issued Thru Employer? Yes No

Subscriber's Employer: _____

Subscriber's Address: _____

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

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Secondary Insurance Carrier: _____

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

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

Group Number: _____ Effective Date (MM/DD/YYYY): _____ Issued Thru Employer? Yes No

Subscriber's Employer: _____

Subscriber's Address: _____

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

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

Relationship: **Father** **Stepfather** **Mother** **Stepmother** **Guardian**

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:** _____

January 11, 2018