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