

Patient Information			
First Name	Last Name	M.I.	Previous Name (if applicable)
Mailing Address		Apt Number	
City/State/Zip			
Home Phone	Cell Phone	Work Phone	
Preferred Method of Contact (Please Select Only One Option) <input type="checkbox"/> Voice <input type="checkbox"/> Text	If voice, please select preferred number for contact <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	If voice, would you be okay with patient information in voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex (Biological Gender) <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Family Physician or Pediatrician	
Marital Status	Employer Name	Social Security Number	
Emergency Contact Name	Relationship to Patient	Emergency Contact Phone Number	

Additional Information Please fill out all sections below	
Email Address	Can we leave a message regarding your medical care and test results? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Race</b> (please select one or multiple) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Unreported/Chose not to Disclose <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian <input type="checkbox"/> More than one race <input type="checkbox"/> Filipino <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan	<b>Ethnicity</b> (please select one) <input type="checkbox"/> Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Spaniard <input type="checkbox"/> Hispanic, Latino/a, or Spanish origin combined <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Mexican <input type="checkbox"/> Unknown <input type="checkbox"/> Mexican American <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other Hispanic, Latino/a, or Spanish Origin
<b>Preferred Language</b> (please select one) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Hindi or Urdu <input type="checkbox"/> Sign Language <input type="checkbox"/> Vietnamese <input type="checkbox"/> Mandarin or Cantonese <input type="checkbox"/> Other _____	
Preferred Pharmacy Name and Location	

Responsible Party If the patient is a minor (under the age of 18) the parent or guardian bringing the patient in will be listed as the guarantor.			
First Name	Last Name		
Date of Birth	Social Security Number	Phone	
Address of Person Responsible		Apt Number	
City/State/Zip	Relationship to Patient		

Primary Medical Insurance	Secondary Medical Insurance
Insurance Company Name	Insurance Company Name
Policy Holder Name	Policy Holder Name
Policy Holder Member ID	Policy Holder Member ID
Policy Holder's Date of Birth	Policy Holder's Date of Birth
Policy Holder's Social Security Number	Policy Holder's Social Security Number
Patient Relationship to Policy Holder	Patient Relationship to Policy Holder

I certify that I have read and agree to AccessHealth's payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to AccessHealth all money to which I am entitled for medical expenses related to the services performed from time to time by AccessHealth, but not to exceed my indebtedness to AccessHealth. I authorize AccessHealth to release any medical information to my insurance carrier or third party payer to facilitate processing of my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. I choose to receive communications from AccessHealth by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to AccessHealth. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT/GUARANTOR SIGNATURE	PRINTED NAME	DATE
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