FREEMAN Health System

NEW PATIENT/UPDATE Date of Birth: _____

PATIENT INFORMATION: (Please Print)

First Name: _____ Middle Intl: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Misc. Phone 1: _____ Preferred Contact Method: _____

Email: _____ Preferred Statement Method: ☐ Electronic ☐ Paper

Date of Birth: _____ Age: _____ S.S#: _____ - _____ - _____ SEX: M F Marital Status: S M D W

Race: ☐Unknown ☐Black, African American ☐Asian ☐White ☐American Indian, Alaska Native ☐Native Hawaiian, Other Pacific Islander ☐Other Primary Language: _____

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown

Employer: _____ Employer's Address: _____

Employer's Phone: _____ Position (Job Title): _____ How long employed?: _____

If Minor, Patient lives with: ☐MOTHER ☐FATHER ☐GRANDPARENT ☐FOSTER PARENT ☐OTHER_____

PERSON TO NOTIFY IN THE EVENT OF AN EMERGENCY: (Other than below)

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

PERSON RESPONSIBLE FOR BILL: (If Minor, Parent or Guardian)

Name _____ S.S. #: _____ - _____ - _____ Date of Birth: _____

Relationship to Patient: _____ Address: _____

Phone: _____ Mobile Phone: _____ Email: _____

Employer: _____ Employer's Address: _____

Employer's Phone: _____ Position (Job Title): _____ How long employed?: _____

SPOUSE INFORMATION:

Name: _____ SS#: _____ - _____ - _____ Date of Birth: _____

Phone: _____ Mobile Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer's Address: _____

Employer's Phone: _____ Position (Job Title): _____

INSURANCE INFORMATION:

PRIMARY INSURANCE NAME: _____ ID#: _____ Group#: _____

Subscriber Name: _____Employer:_____ Date of Birth: _____ SS#: ____ - ____ - ____

SECONDARY INSURANCE NAME: _____ ID#: _____ Group#: _____

Subscriber Name: _____Employer:_____ Date of Birth: _____ SS#: ____ - ____ - ____

TERTIARY INSURANCE NAME: _____ ID#: _____ Group#: _____

Subscriber Name: _____Employer:_____ Date of Birth: _____ SS#: ____ - ____ - ____

REFERRED BY: _____ **REFERRING PHYSICIAN:** _____

☐ **I acknowledge that I have had the opportunity to read and/or receive a copy of System's Notice of Privacy Practices. A complete copy Of the Notice is available at the Admissions desk.**

Patient or Guardian's Signature: _____ Date: _____