JALH PHYSICIAN CLINICS

FIRST NAME_____ MIDDLE INITIAL_____ LAST NAME_____

If Minor, Name of Guardian/Parent_____

Birthday____/_____/_____ SS#_____-_____-_____ MAIDAN NAME_____

ADDRESS(WHERE YOU RECEIVE YOUR MAIL)_____

CITY_____ STATE_____ ZIP_____

HOME PHONE #_____ CELL PHONE #_____ MARITAL STATUS_____

PLACE OF EMPLOYMENT_____ WORK #_____

PREFERRED LANGUAGE: ENGLISH SPANISH FRENCH OTHER_____

RELIGION:_____ RACE_____

EMERGENCY CONTACT _____ PHONE #_____RELATIONSHIP_____

EMAIL ADDRESS:_____ USED TO ACCESS OUR PATIENT PORTAL

PHARMACY NAME_____ PHONE #_____

PRIMARY CARE PHYSICIAN_____ PHONE#_____

INSURANCE NAME_____ POLICY HOLDER_____

POLICYHOLDER DOB____/____/_____SS#_____-_____-_____RELATIONSHIP TO PT_____

POLICY HOLDERS PLACE OF EMPLOYMENT_____ PHONE NUMBER_____

I hereby authorize *JALH PHYSICIAN CLINICS* to release and/or receive any and all information: (1) information requested by my insurance company or workman's compensation carrier. (2) Information to any hospital or physician you may be referred to and/or (3) information from hospitals or physicians who have previously rendered you treatment. I understand that I am ultimately responsible for payment of any and all charges and if this assignment of claim is rejected, modified, or not paid within a reasonable time after it has been filed, it may be my responsibility to pay any unpaid charges in full. I hereby authorize payment of medical benefits to *JALH PHYSICIAN CLINICS*.

PATIENTS NAME (PRINT)_____

SIGNATURE OF PATIENT OR GUARDIAN:_____ DATE _____/_____/_____