ENGLEWOOD HEALTH
PHYSICIAN NETWORK

Patient Information Form

TODAYS DATE / /

LAST NAME | FIRST NAME | MI | SEX ☐ Male ☐ Female | GENDER IDENTITY (optional) ☐ Male ☐ Female ☐ Other ☐ Transgender Male (FTM) ☐ Transgender Female (MTF)

ADDRESS | CITY | STATE | ZIP CODE

MARITAL STATUS ☐ Married ☐ Divorced ☐ Single ☐ Widowed | DATE OF BIRTH / / | EMAIL | SSN # - -

HOME PHONE ( ) ☐ Preferred?
May we leave you a message on this number? ☐ YES ☐ NO ☐ Brief ☐ Extended

CELL PHONE ( ) ☐ Preferred?
May we leave you a message on this number? ☐ YES ☐ NO ☐ Brief ☐ Extended

WORK PHONE ( ) ☐ Preferred?
May we leave you a message on this number? ☐ YES ☐ NO ☐ Brief ☐ Extended

Are you part of the Bloodless Medicine Program? ☐ YES ☐ NO

Do you have a Living Will/Advance Directive? ☐ YES ☐ NO

RACE ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ White

ETHNICITY ☐ Hispanic or Latin ☐ Non Hispanic or Latin ☐ Prefer not to answer

PRIMARY LANGUAGE ☐ Chinese ☐ English ☐ Farsi ☐ French ☐ Greek ☐ Hindi ☐ Indian ☐ Italian ☐ Japanese ☐ Korean ☐ Russian ☐ Spanish ☐ Other

DO YOU NEED A TRANSLATOR? ☐ YES ☐ NO

PHARMACY NAME | PHONE ( )

PHARMACY ADDRESS | CITY | STATE | ZIP CODE

EMERGENCY CONTACT #1 | RELATIONSHIP | EMERGENCY CONTACT PHONE ( )

EMERGENCY CONTACT #2 | RELATIONSHIP | EMERGENCY CONTACT PHONE ( )

Which provider do you see to meet most of your healthcare needs?

PRIMARY CARE PROVIDER | PHONE ( )

PRIMARY CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

REFERRING CARE PROVIDER | PHONE ( )

REFERRING CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

OTHER CARE PROVIDER | PHONE ( )

OTHER CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

OTHER CARE PROVIDER | PHONE ( )

OTHER CARE PROVIDER ADDRESS | CITY | STATE | ZIP CODE

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EMPLOYMENT INFORMATION

EMPLOYER NAME | OCCUPATION/POSITION

EMPLOYMENT STATUS
☐ Employed Full-time ☐ Employed Part-Time ☐ Self-employed ☐ Retired ☐ On active military duty ☐ Reserves ☐ Other

INSURANCE/PAYMENT INFORMATION

PRIMARY INSURANCE *Which insurance should be billed first?*

SUBSCRIBER NAME | IN WHOSE NAME IS YOUR HEALTH INSURANCE POLICY?

SUBSCRIBER SSN # - - | SUBSCRIBER DATE OF BIRTH / / | RELATIONSHIP TO SUBSCRIBER

SUBSCRIBER EMPLOYER

SUBSCRIBER EMPLOYER ADDRESS | CITY | STATE | ZIP CODE

SUBSCRIBER GENDER
☐ Male ☐ Female ☐ Transgender ☐ Other

PRIMARY INSURANCE COMPANY | POLICY # | GROUP #

INSURANCE COMPANY ADDRES | CITY | STATE | ZIP CODE

EMERGENCY CONTACT PHONE #
( )

ADDITIONAL INSURANCE *Which insurance should be billed second? This may not apply to you.*

SUBSCRIBER NAME | IN WHOSE NAME IS YOUR HEALTH INSURANCE POLICY?

SUBSCRIBER SSN # - - | SUBSCRIBER DATE OF BIRTH / / | RELATIONSHIP TO SUBSCRIBER

SUBSCRIBER EMPLOYER

SUBSCRIBER EMPLOYER ADDRESS | CITY | STATE | ZIP CODE

SUBSCRIBER GENDER
☐ Male ☐ Female ☐ Transgender ☐ Other

OTHER INSURANCE COMPANY | POLICY # | GROUP #

ACKNOWLEDGEMENT/AUTHORIZATION

I CERTIFY THAT ALL INFORMATION I PROVIDED ABOVE IS ACCURATE AND TRUE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FOR ANY SERVICES FURNISHED TO ME BY THIS PHYSICIAN GROUP. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I AUTHORIZE THE RELEASE OF MY INFORMATION CONCERNING MY HEALTHCARE TO MY INSURANCE COMPANY FOR THE PURPOSE OF REVIEWING AND PROCESSING MEDICAL CLAIMS FOR PAYMENT.

SIGNATURE | RELATIONSHIP TO PATIENT | DATE / /