Today's Date_____

3 A D M

Patient's Name _____
First *Middle* *Last* *Maiden*

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Other

Birth Date: _____ Social Security # _____ Sex: ❒ M ❒ F

Address _____
Street *City* *State* *Zip Code*

Home Phone _____ Cell Phone _____ Work Phone _____
Area Code *Area Code* *Area Code*

Email Address _____

Preferred Primary Care Provider _____

Covenant Clinic collects this demographic information to ensure high quality health care is provided to all of our patients. Thank you.

Race		**Ethnicity**		**Spoken Language**	
Black		Hispanic		English	
White		Non-Hispanic		Other:	
American Indian/Alaskan Native					
Asian					
Native Hawaiian/Pacific Islander					

Multiracial: ❒ Alaskan Native/American Indian ❒ Asian ❒ Black/African American ❒ Hawaiian/ Pacific Islander ❒ White/Caucasian ❒ Unknown ❒ Declined

Patient's Employer Information

Name of Employer _____ Status: ❒ Full-Time ❒ Part Time

Occupation _____ Date of Employment _____

Employer's Address _____

Spouse Information

Name _____ Date of Birth _____

Social Security # _____ Telephone _____

Address _____
Street *City* *State* *Zip Code*

Employer _____ Work Number _____

PLEASE COMPLETE OTHER SIDE

Wheaton Franciscan Healthcare

❒ **Covenant Clinic Site** _____

Patient Information

474187 4/1/14 tm

TOP OF LABEL
PATIENT LABEL MUST BE PLACED HERE
LABEL CANNOT BE IN ANY OTHER LOCATION OR POSITION
BOTTOM OF LABEL

3 A D M

If patient is under the age of 18 please complete

Father's Name _____ Date of Birth _____
Social Security # _____ Marital Status _____ Work Phone _____
Address _____ Home Phone _____
Employer _____
Mother's Name _____ Date of Birth _____
Social Security # _____ Marital Status _____ Work Phone _____
Address _____ Home Phone _____
Employer _____

Nearest Relative or Person to Notify in Case of an Emergency

Name _____ Phone _____

Relationship _____

Insurance Form

Patient's Name _____ **DOB** _____

Relationship to Policy Holder: *(Examples: Husband/Wife, Son/Daughter, Stepchild, Mother/Father)* _____

Primary Insurance

Name of Insurance Company _____
Effective Date _____ Primary Care Physician _____
Policy # _____ Group # _____ Pre-certification? ❒ Procedure ❒ Hospitalization
Policy Holder's Name _____ MALE / FEMALE
Address _____ Phone # _____
Street City State Zip
Birth Date _____ Social Security # _____
Policy Holder's Employer _____ Hire Date _____ Status ❒ PT ❒ FT
Address _____ Phone # _____
Street City State Zip

Secondary Insurance

Name of Insurance Company _____
Effective Date _____ Primary Care Physician _____
Policy # _____ Group # _____ Pre-certification? ❒ Procedure ❒ Hospitalization
Policy Holder's Name _____ MALE / FEMALE
Address _____ Phone # _____
Street City State Zip
Birth Date _____ Social Security # _____
Policy Holder's Employer _____ Hire Date _____ Status ❒ PT ❒ FT
Address _____ Phone # _____
Street City State Zip

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS: I hereby authorize insurance and/or Medicare payments for services rendered to me, or my dependents, to be paid to Covenant Clinic. I hereby agree to pay Covenant Clinic any and all charges that exceed or that are not covered by my health insurance coverage. I also authorize Covenant Clinic to release all medical information necessary to process my claims.

Signed _____ **Date** _____

Wheaton Franciscan Healthcare

❒ **Covenant Clinic Site** _____

Patient Information

474187 4/1/14 tm

TOP OF LABEL
PATIENT LABEL MUST BE PLACED HERE
LABEL CANNOT BE IN ANY OTHER
LOCATION OR POSITION
BOTTOM OF LABEL