Date:___/____/_____

BENSON Health Clinic

PATIENT INFORMATION *(Please Print)*

Last Name | First | MI | Marital Status ☐ M ☐ S ☐ D ☐ W

Street Address | City | State | Zip Code

Mailing Address (if different) | City | State | Zip Code

Home Phone | Cell Phone | Gender ☐ M ☐ F ☐ T | Birth Date | Age

Primary Care Physician | Referred by: ☐ Primary Care Physician ☐ Relative ☐ Friend ☐ Yellow Pages ☐ Newspaper ☐ Other ☐ Website

RESPONSIBLE PARTY INFORMATION

Name of Person Responsible for Bill | Address | Phone Number ( )

Employer | Work Number ( )

PRIMARY INSURANCE INFORMATION

Insurance Company | Employer | ID/Policy Number | Group Number | Effective Date

Address of Insured Party | City | State | Zip Code | Phone Number ( )

Named of Insured Party | Social Security Number | Birthdate | Relationship to Patient

SECONDARY INSURANCE INFORMATION

Insurance Company | Employer | ID/Policy Number | Group Number | Effective Date

Address | City | State | Zip Code | Phone Number ( )

Named of Insured Party | Social Security Number | Birth Date | Relationship to Patient

PERSON TO CONTACT IN CASE OF EMERGENCY

Name | Relationship to Patient | Phone Number ( )

In order to comply with the new Health Care Mandates, Benson Health Clinic is *required* to collect the following information.

Race: ☐White ☐ Asian ☐ Black/African Amer. ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Hispanic or Latin ☐ Refused

Ethnicity: ☐ Non-Hispanic or Latin ☐ Hispanic ☐ Refused

Preferred Language: ☐ English ☐ Spanish ☐ Indian (Includes Hindi & Tamil) ☐ Korean ☐ Other:_____