Anchor Bay Clinic Family Medical Center

32901 23 Mile Rd, Suite 100
Chesterfield, MI 48047

Please print.

Today's date:	PCP:	Patient email:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Phone No,: Home / Mobile (circle one)	Language:	Race:	Birthdate: / /	Age:	Sex: M / F

Street address:	Social Security no.:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Were you referred to our clinic/ how did you hear about us?
Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birthdate: / /	Address (if different):
Is this person a patient here? Yes / No		Home phone no.: ( )
Occupation:	Employer:	Employer address:
Is this patient covered by insurance? Yes / No		Employer phone no.: ( )

What is your primary insurance provider?					
Subscriber's name:	Subscriber's SSN:	Birthdate: / /	Group No.:	Policy no.:	Co-pay: $
Relationship to subscriber (circle one): Self / Spouse / Child / Other: _____					
Name of secondary insurance (if applicable):	Subscriber's name:		Group No.:	Policy no.:	
Relationship to subscriber (circle one): Self / Spouse / Child / Other: _____					

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address):	Relationship to patient:
Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Anchor Bay Clinic Family Medical Center and my insurance company to release any information required to process my claims.

_____ _____

Patient/ Guardian Signature Date