□ **New Patients**

Patient Information

□ **Update**

Insurance card copied □ **Eureka Family Practice**

Date:___/___/___ ***I am changing my:*** □ ***Name*** □ ***Address*** □ ***Insurance Co.***

□ **Edward Olsgard, MD** **Caroline Connor, MD** □ **Debbie Barrow-Vrieze, FNP** □ **Rachel Bailey, D.O.**
□ **Leo Leer, MD** □ **Gregory Holst, MD** □ **John Brimlow, PA-C** □ **Katie Schoenfield, FNP**
□ **Steven Korenstein, MD**

Patient Personal Information

□ **Male** □ **Female** **Primary Language**_____

Name: _____ ___/___/___ _____/_____/_____
Last Name First Name Middle Initial Date of Birth Social Security Number

Previous Name (if name change):_____Race_____

Street Address:_____ (Apt#___) City:_____State:____Zip:_____

Mailing Address:_____ City:_____State:____Zip:_____

Home Phone: ( ) ___-_____Work Phone: ( ) ____-_____ Cell/Pager: ( ) _____-_____

Employer/Name of School: _____

Spouse's Name: _____Spouse's Work #: ( ) _____-_____

Emergency Contact: _____Phone #: ( ) _____-_____

If Patient is a minor; Responsible Parties Information: Name: _____

Address: _____ Phone #: ( )_____-_____

Patient's Insurance Information

Please present new insurance cards to receptionist.

PRIMARY Insurance Company's Name: _____

Insurance Co. Address: _____

Subscriber Name: _____Date of birth:____/____/____ Relationship to insured: □ Self □ Spouse □ Other □ Child

ID #: _____Group #: _____Effective date: _____

SECONDARY Insurance Company's Name: _____

Insurance Co. Address: _____

Subscriber Name: _____Date of birth:____/____/____ Relationship to insured: □ Self □ Spouse □ Other □ Child

ID #: _____Group #: _____Effective date: _____

Assignment of Benefits/Notice of Privacy Practices

I authorize my insurance company to send my benefits directly to Eureka Family Practice. I also authorize Eureka Family Practice to send any medical information to my insurance company that they need to process my claims. I understand that I am responsible to resolve any benefit disputes with my carrier, and to pay any balance whether or not it may be a covered service.

Patient/Parent/Guardian Signature _____**Date** _____