WELCOME
TO
Avere Healthcare Clinic

Confidential Patient Information (Rev 9/16/11)

Date of Birth: _____ Social Security Number: _____ - _____ - _____

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City/State/Zip: _____

E-mail Address: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Gender: ☐ Male ☐Female Marital Status: ☐ Single ☐ Married ☐Partnered ☐Divorced ☐Separated

EMPLOYER INFORMATION-PATIENT

Name of Employer: _____ Work Phone: (_____) _____

Business Address: _____

INSURANCE INFORMATION

What type of insurance do you have?

☐ Health Insurance ☐ Tricare ☐ Medicare ☐Medicaid ☐Work Comp ☐Private Pay

Name of Primary Insurance Plan: _____

Policy #: _____ Group #: _____

Claims Address & Phone Number: _____

Name of Secondary Insurance Plan: _____

Policy #: _____ Group #: _____

Claims Address & Phone Number: _____

Fill out this box ONLY if the patient is NOT the primary insurance card holder

Relationship of patient to primary insured: ☐Spouse ☐Child ☐Other_____

Primary Insured's Name: _____

Primary Insured's Address (*if different from patient's address*): _____

_____ Primary Insured's Date of Birth: _____

Primary Insured's Social Security #: _____ - _____ - _____

Primary Insured's Employer: _____

In the event of an emergency, who should we contact? Phone: _____

Name: _____ Relationship: _____

I acknowledge that the information that I provided above is accurate.

_____ _____ _____

Signature **Printed Name** **Date**