CPG Family Medical Center

1121 NEO Loop
Grove, Ok 74344
P 918.786.8448
F 918.786.9502

Patient Demographics

PATIENT INFORMATION

Name (Last, First Middle)	SSN #	Birthdate	Sex

Please make a selection from each of the following lists

Ethnicity
- ◊ Hispanic or Latino
- ◊ Non Hispanic or Latino
- ◊ Unknown
- ◊ Patient Refused
- ◊ Other _____

Race
- ◊ American Indian or Alaska Native
- ◊ Asian
- ◊ Black or African American
- ◊ Native Hawaiian or Other Pacific Islander
- ◊ White
- ◊ Unknown
- ◊ Patient Refused
- ◊ Other Race _____

Preferred Language
- ◊ Arabic
- ◊ Bulgarian
- ◊ Central Khmer
- ◊ Chinese
- ◊ English
- ◊ French
- ◊ German
- ◊ Haitian; Haitian Creole
- ◊ Unknown
- ◊ Patient Refused
- ◊ Hebrew
- ◊ Hindi
- ◊ Italian
- ◊ Japanese
- ◊ Korean
- ◊ Polish
- ◊ Portuguese
- ◊ Russian
- ◊ Spanish
- ◊ Other _____

Home Phone	Day Phone	Email Address

PHYSICAL ADDRESS	BILLING/MAILING ADDRESS	Referring Physician
CITY, STATE, ZIP	**CITY, STATE, ZIP**	**Primary Care Provider**

Marital Status	Student Status	Smoking Status	Veteran
◊ Married ◊ Single ◊ Divorced ◊ Widowed ◊ Other	◊ Fulltime ◊ Part time	◊ Yes ◊ No	◊ Yes ◊ No

Emergency Contact Name (not living with you)	Relationship to Patient	Emergency Contact Phone Number

SPOUSE / Parent — Name (Last, First Middle)	SSN#	Birthdate	Primary Language	Sex

Phone	Email

EMPLOYMENT INFORMATION

Primary Employer	Secondary Employer
Address	**Address**
City, State, Zip	**City, State, Zip**

Work Phone	Contact Person	Work Phone	Contact Person

RESPONSIBLE PARTY INFORMATION (Different than patient) or LEGUAL GUARDIAN (if not living with patient)

Name (Last, First Middle)	SSN #	Birthdate	Primary Language	Sex

Home Phone	Day Phone	Email Address

PHYSICAL ADDRESS	BILLING/MAILING ADDRESS	Relationship to Patient
CITY, STATE, ZIP	**CITY, STATE, ZIP**	**Marital Status** ◊ Married ◊ Single ◊ Divorced ◊ Widowed ◊ Other

I attest the provided information on this document is correct and true at the time this document was filled out. I understand that if at any time any of the provided contact information changes, it is my responsibility to update this information with this facility. I also agree that a photocopy of this document shall be as valid as the original

SIGNATURE OF PATIENT/GUARDIAN DATE

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PATIENT INSURANCE STATUS

PATIENT NAME

Name (Last, First Middle)	SSN #	Birthdate

Please initial beside the statement that applies.

1_____ I DO NOT have insurance coverage at the time this form was filled out. I understand I or my responsible party will be charged for my services rendered at the Private Pay (uninsured) Rate.

2_____ I attest as the patient or guardian of the patient all insurance information provided on this document is correct and true at the time this document was filled out. I also understand if my insurance status changes throughout the course of treatment and care by this facility, it is my responsibility as the patient or responsible party to inform this facility of the change as soon as possible, otherwise I or my responsible party may become financiallty responsible for any and all services not processed or paid by the insurance company information on file at this facility.

PRIMARY INSURANCE

Name of Insurance Company			Policy #	
Address of Insurance Company			Group #	
City, State, Zip			COPAY Amount $	
Name of Policy Holder	Birthdate	SSN#	Deductible $	
Relationship to Patient		Phone Number	Effective Date	Expiration Date
PHYSICAL ADDRESS of Policy Holder	CITY, STATE, ZIP	BILLING/MAILING ADDRESS of Policy Holder		CITY, STATE, ZIP

SECONDARY INSURANCE

Name of Insurance Company			Policy #	
Address of Insurance Company			Group #	
City, State, Zip			COPAY Amount $	
Name of Policy Holder	Birthdate	SSN#	Deductible $	
Relationship to Patient		Phone Number	Effective Date	Expiration Date
PHYSICAL ADDRESS of Policy Holder	CITY, STATE, ZIP	BILLING/MAILING ADDRESS of Policy Holder		CITY, STATE, ZIP

I hereby authorize payment directly to Community Physicians Group and any consulting physicians insurance benefits otherwise payable to me or my minor dependants. I understand that I am financially responsible for charges not covered by this authorization. I hereby authorize release of information requested of Community Physicians Group and any consulting physician. I agree to allow Community Physicians Group to release medical information on me or any of my minor dependants if requested by any insurance company for the purpose of determining benefits payable.

I agree that a photocopy of this agreement shall be as valid as the original.

SIGNATURE OF PATIENT/GUARDIAN DATE