# TROY FAMILY PRACTICE, P.L.L.C.

Legal Name: _____, _____, _____Sex: M/F
Last First Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

**Primary Phone #**:_____ Alternate Phone: _____

Social Security #:XXX-XX-_____ Birth Date: _____

Are you: Married Single Divorced Widowed Primary Language: _____

Race: _____ Ethnic Background: **Hispanic/Latino or Not Hispanic/Latino**

**E-mail Address**:_____

Employer: _____

Legal Guardian/Parent (If patient is minor) or Spouse: _____

In case of emergency, contact: _____

Relationship: _____ Phone #:_____

Do you have an Advanced Directive or Living Will? Yes / No

How did you hear about our office: Family Member Friend Co-worker Newspaper ad Web Site
Other_____

IN ACCORDANCE WITH HIPPA REGULATIONS, IF YOU WOULD LIKE THIS OFFICE TO RELEASE/DISCUSS YOUR MEDICAL INFORMATION WITH SOMEONE OTHER THAN YOURSELF, PLEASE COMPLETE THE FOLLOWING:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

I AUTHORIZE THE DOCTOR TO BILL MY INSURANCE CARRIER AND IF NECESSARY TO RELEASE ANY MEDICAL OR PERSONAL INFORMATION REQUIRED TO PROCESS THE INSURANCE CLAIM ON MY BEHALF.

Signature: _____ Date: _____

Primary Insurance: _____Policy Holder: _____ Birth Date_____
Subscriber Subscriber