



PCA – PRIMARY CARE ASSOCIATES
 4211 Joe Ramsey Blvd. Ste 100
 Greenville, Texas 75401

Today's Date	Reviewed By

PATIENT INFORMATION

A PARENT OR GUARDIAN MUST BE PRESENT, IF PATIENT IS A MINOR OR STUDENT (UNDER 18 YR OF AGE)

Last	First	MI
Street		P.O. Box or Apartment #
City	State	Zip Code

Home Phone	Cell Phone	Employer's Name	Work Phone
Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____/____/____	Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single
Person to contact in case of emergency	Relationship to patient	Home Phone	Work Phone

PRIMARY INSURANCE:

Subscriber (PERSON WITH INSURANCE)	Relationship to patient	Date of Birth	Social Security Number
Subscriber Employer (for referrals)			
Guarantor (PERSON RESP. FOR PYMT)	Relationship to patient	Date of Birth	Social Security Number
Address of Guarantor if different than Patient:			

SECONDARY INSURANCE:

Subscriber (PERSON WITH INSURANCE)	Relationship to patient	Date of Birth	Social Security Number
Subscriber Employer (for referrals)			

Drug Allergies

PATIENT AUTHORIZATION

I hereby grant consent to all healthcare providers of PCA-Primary Care Associates to evaluate and treat. I authorize PCA – Primary Care Associates to release to my insurance company any information required, including the diagnosis and records in the course of my exam or treatment. I understand it is the patient's responsibility to let us know if pre-certification is required for any office visit, in-patient, out-patient admissions as well as any surgeries. I understand that the failure to notify our office may cause me increased out of pocket expenses such as denied claims and reduced benefits. I also understand that it is the patient's responsibility to select a PCP prior to my services and it must be a PCA provider. I hereby authorize payment directly to PCA – Primary Care Associates for the medical and/or surgical benefits otherwise payable to me, but not to exceed charges made for such treatment. I understand that I am financially responsible for the charges not covered by my insurance.

X

 Patient OR Guarantor's Name

 Date