BIENVILLE
FAMILY CLINIC

PATIENT NAME: FIRST_____MI_____LAST:_____
ADDRESS:_____CITY:_____STATE:____ZIP:_____
DOB:_____AGE:_____M___F___ MARITAL STATUS___S___M___W___D
SOCIAL SECURITY:_____HOME PHONE:_____CELL:_____
PHARMACY NAME AND LOCATION:_____

NEXT OF KIN:

NAME OF PERSON WITH WHOM WE MAY SHARE INFORMATION ABOUT YOUR ACCOUNT AND MEDICAL RECORDS?
NAME:_____RELATIONSHIP:_____PHONE #:_____
NAME:_____RELATIONSHIP:_____PHONE #:_____

RESPONSIBLE PARTY:

NAME:_____MI____LAST_____
ADDRESS:_____CITY:_____STATE:_____ZIP:_____
DOB:_____M___F___ AGE_____SOCIAL SECURITY:_____
RELATIONSHIP TO PATIENT_____HOME PHONE:_____
CELL:_____EMPLOYER:_____
EMPLOYERS ADDRESS:_____
PRIMARY INSURANCE:_____
INSURED NAME:_____DOB:_____
SUBSCRIBER NUMBER: _____ GROUP NUMBER: _____
RELATIONSHIP TO PATIENT: SELF___SPOUSE___DEPENDANT___OTHER____ IS THIS A GROUP PLAN?___Y____N
EMPLOYER:_____
EMPLOYER'S ADDRESS:_____
SECONDARY INSURANCE:_____
INSURED NAME:_____DOB:_____
SUBSCRIBER NUMBER: _____ GROUP NUMBER: _____
RELATIONSHIP TO PATIENT: SELF___SPOUSE___DEPENDANT___OTHER____ IS THIS A GROUP PLAN?___Y____N
EMPLOYER:_____
EMPLOYER'S ADDRESS:_____

HAVE YOU BEEN IN THE HOSPITAL /EMERGENCY ROOM?
Y___N___WHEN/WHERE_____

HAVE YOU BEEN SEEN AT ANOTHER CLINIC?
Y____N____WHEN/WHERE:_____

HAVE YOU BEEN SEEN BY OTHER DOCTORS: Y____N____WHO:_____

PLEASE FAX THIS FORM AND A COPY OF INSURANCE CARDS TO 318 263-2008

BIENVILLE FAMILY CLINIC
TELEPHONE 318-263-7970