CovenantHealth℠
Medical Group

A. PATIENT INFORMATION

PATIENT: _____ SSN: _____
LAST FIRST MIDDLE

DRIVER'S LICENSE NUMBER: _____ STATE: _____ BIRTH DATE: _____

GENDER: ☐ M ☐ F MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

ETHNICITY: ☐ HISPANIC, LATINO, OR SPANISH ORIGIN ☐ NOT HISPANIC, LATINO, OR SPANISH ORIGIN

RACE: ☐ ASIAN ☐ BLACK/AFRICAN-AMERICAN ☐ CAUCASIAN/WHITE ☐ HISPANIC ☐ NATIVE AMERICAN/ALASKAN NATIVE
☐ NATIVE HAWAIIAN/PACIFIC ISLAND ☐ OTHER ☐ REFUSE

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: ( ) _____ ☐ HOME ☐ WORK ☐ CELL REMINDER CALL: ☐ YES ☐ NO

CELL PHONE: ( ) _____ (ALSO REQUIRED FOR APPT REMINDER TEXT)

EMPLOYMENT STATUS: ☐ EMPLOYED ☐ STUDENT ☐ RETIRED ☐ OTHER

EMPLOYER: _____ PATIENT'S WORK PHONE: ( ) _____

PATIENT'S ADDITIONAL PHONE: ( ) _____ E-MAIL: _____

EMERGENCY CONTACT NAME: _____ PHONE:( )_____

EMERGENCY CONTACT RELATIONSHIP: _____

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS: ☐ YES ☐ NO

PRIMARY CARE PHYSICIAN: _____ OB/GYN IF APPLICABLE: _____

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ SIGN LANGUAGE ☐ OTHER: _____

B. GUARANTOR INFORMATION (IF PATIENT IS UNDER 18)

GUARANTOR NAME: _____ RELATIONSHIP OF PATIENT TO GUARANTOR: ☐ CHILD ☐ OTHER: _____

DRIVER'S LICENSE NUMBER: _____ STATE: _____

GUARANTOR MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

GUARANTOR PHONE: ( ) _____ GUARANTOR SSN: _____ GUARANTOR DOB: _____

GUARANTOR EMPLOYER: _____ GUARANTOR WORK PHONE: ( ) _____

C. PRIMARY INSURANCE INFORMATION

(IF PROVIDING CURRENT INSURANCE CARD, SKIP C & D)

NAME OF COMPANY: _____

MEMBER NUMBER/CERTIFICATE NUMBER: _____ GROUP/PLAN: _____

POLICY EFFECTIVE DATE: _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER/INSURED: ☐ CHILD* ☐ OTHER* ☐ SELF ☐ SPOUSE*
(*IF PATIENT IS NOT THE SUBSCRIBER, PLEASE COMPLETE THE INFORMATION BELOW)

SUBSCRIBER NAME: _____ BIRTH DATE: _____

SUBSCRIBER'S EMPLOYER: _____

D. SECONDARY INSURANCE INFORMATION

NAME OF COMPANY: _____

MEMBER NUMBER/CERTIFICATE NUMBER: _____ GROUP/PLAN: _____

POLICY EFFECTIVE DATE: _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER/INSURED: ☐ CHILD* ☐ OTHER* ☐ SELF ☐ SPOUSE*
(*IF PATIENT IS NOT THE SUBSCRIBER, PLEASE COMPLETE THE INFORMATION BELOW)

SUBSCRIBER NAME: _____ BIRTH DATE: _____

SUBSCRIBER'S EMPLOYER: _____