|  |  |
| --- | --- |
| **Basic Information** | |
| |  |  |  | | --- | --- | --- | | Last Name: | First Name: | Middle Initial: | | Date of Birth: | Sex: □ Male □ Female | Marital status: | | Home Address: | | | | City: | State: | ZIP: | | Phone: ( ) | Email address: | | | |
| **Personal Information** |  |
| |  |  |  | | --- | --- | --- | | SSN: | [ ] [ ] [ ] – [ ] [ ] – [ ] [ ] [ ] [ ] | | |  | | | | Place of employment: |  | | | Occupation: |  | | | Race: |  | | | Emergency contact: |  | | |  | Relationship: |  | |  | Contact number: |  | | |
| **Insurance Coverage** |  |
|  | |
| □ I do not have Medicaid coverage, Medicare, or other insurance coverage.   |  |  |  |  | | --- | --- | --- | --- | | **Primary Insurance** | | | | | Carrier name: |  | ID #: |  | | Subscriber Name: |  | Group #: |  | | Subscriber Date of Birth: |  | Relation to patient: | □Self □Spouse □Child □Other: | | |
| □ I have **secondary insurance**. |  |

|  |  |
| --- | --- |
| I certify that all the information provided by me on this form is true and correct and grant permission for Hometown Healthcare LLC to proceed with the provision of healthcare. | |
| Print Name: | |
| Signature: | Date: |