**HEALTHCARE INTEREST FORM**

**Welcome to MMC!** Please fill out this information to the best of your knowledge. *\*\* Note: The demographic information listed on your insurance card/ID will be listed on your medical record and for setting up appointments for you at this time.*

|  |  |
| --- | --- |
| **DATE** |  |

**Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **LAST NAME** |  | **FIRST NAME** |  | **M.I.** |  |
| **DOB** |  | **AGE** |  | **GENDER**  |  |
|  **STREET ADDRESS** |  | **APT./ UNIT #** |  |
|  **CITY** |  | **STATE** |  | **ZIPCODE** |  |
| **HOME**  |  | **MOBILE** |  | **EMAIL** |  |

**Emergency Contacts** *(please provide information for those who may be contacted in case of an emergency):*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NAME** |  | **PHONE** |  | **RELATIONSHIP** |  |
| **NAME** |  | **PHONE** |  | **RELATIONSHIP** |  |

**Primary Insurance Coverage: *(If insured by TRICARE, please add the policyholder’s SOCIAL SECURITY NUMBER to ensure benefits)***

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURANCE COMPANY** |  | **POLICY HOLDER** |  |
|  **SUBSCRIBER ID** |  | **GROUP NUMBER** |  |

**Secondary Insurance Coverage***: (if applicable)*

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURANCE COMPANY** |  | **POLICY HOLDER** |  |
| **SUBSCRIBER ID** |  | **GROUP NUMBER** |  |

**General Patient Information:**

|  |  |
| --- | --- |
| **Primary Care Provider Name** |  |
| **Phone Number** |  | **Fax** |  |
| **Address** |  |
| **City** |  | **State** |  | **Zip** |  |

 **Relationship Status**:[ ] Single [ ]  Married [ ] Separated [ ]  Widowed [ ]  Divorced [ ]  Other

 EMPLOYED: YES\_\_\_\_ NO: \_\_\_\_\_\_\_

**\*\* IF YOU ARE UNINSURED, PLEASE LET US KNOW SO THAT WE CAN HELP YOU OBTAIN MEDICAL ASSISTANCE. \*\***