**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. \*\***