DELAWARE FAMILY CARE ASSOCIATES
2700 SILVERSIDE ROAD SUITE # 2
WILMINGTON, DE 19810
302-478-8421

PATIENT INFORMATION

PLEASE PRINT YOUR NAME AS IT APPEARS ON YOUR INSURANCE CARD

PRIMARY DOCTOR LISTED ON YOUR CARD: _____

PATIENT'S NAME: _____ **S.S.#:** ___ - ___ - ___

PATIENT'S DATE OF BIRTH: _____ **AGE:** _____ **SEX:** **M / F**

ADDRESS: _____
CITY **STATE** **ZIP**

HOME PHONE NUMBER: _____ **CELL PHONE:** _____

WORK PHONE: _____ **E-MAIL ADDRESS:** _____

MARITAL STATUS: **SINGLE** **MARRIED** **DIVORCED** **WIDOWED**

OCCUPATION: _____ CIRCLE: **FULL TIME** **PART TIME** **UNEMPLOYED**

EMERGENCY CONTACT: _____ ***PHONE:*** _____ ***RELATIONSHIP:*** _____

INSURANCE INFORMATION

A COPY OF YOUR INSURANCE CARD MUST BE PRESENTED IN ORDER FOR OUR OFFICE TO BILL TO YOUR INSURANCE COMPANY. IF NO CARD IS GIVEN, THE PATIENT WILL BE RESPONSIBLE FOR THE VISIT.
PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT.

NAME OF PRIMARY INSURANCE: _____

INSURED'S NAME: _____ **INSURED DATE OF BIRTH:** _____

S.S.#: ___ - ___ - ___ **RELATIONSHIP:** _____ **INSURED'S EMPLOYER:** _____

POLICY /ID#: _____ **GROUP #:** _____

SECONDARY INSURANCE: _____

INSURED'S NAME: _____ **INSURED DATE OF BIRTH:** _____

S.S.#: ___ - ___ - ___ **RELATIONSHIP:** _____ **INSURED'S EMPLOYER:** _____

POLICY /ID#: _____ **GROUP #:** _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE EITHER BY ME OR ON MY BEHALF TO DELAWARE FAMILY CARE ASSOCIATES, FOR ANY SERVICES FURNISHED TO ME BY DELAWARE FAMILY CARE ASSOCIATES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

NEW PATIENTS: I HAVE RECEIVED A COPY OF THE PRACTICE'S PRIVACY NOTICE AND WELCOME MATERIALS. INITIAL: _____

SIGNATURE: _____ **DATE:** _____