GROVE MEDICAL ASSOCIATES, INC.

Welcome to our practice. Please print all information.

Is this visit related to Worker's Compensation? □ Yes □ No
Is this visit related to a Motor Vehicle Accident/Personal Injury? □ Yes □ No

PATIENT INFORMATION:
Name: _____ DOB_____ □ Male □ Female
Mailing Address: _____ City:_____ State: _____ Zip:_____
Street Address (if different from above): _____
Phone Numbers: Home:_____ Work:_____ Cell:_____
Email Address: _____
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partner
Who is your primary caregiver at home? □ Self □ Spouse □ Other

IF PATIENT IS A CHILD:
Father's Name:_____ DOB:_____
Mother's Name_____ DOB:_____

PRIMARY INSURANCE
Name:_____
Policy Number:_____
Group Number:_____
Insured Name:_____ DOB:_____

SECONDARY INSURANCE
Name:_____
Policy Number:_____
Group Number:_____
Insured Name:_____ DOB:_____

RESPONSIBLE PARTY *(if different from the patient) person responsible for bills, not necessarily the insurance subscriber:*
Name:_____ DOB:_____ Relationship to Patient: _____
Mailing Address:_____ City_____ State: _____ Zip:_____
Phone Numbers: Home:_____ Work:_____ Cell:_____
Email Address:_____

EMERGENCY CONTACT:
Name:_____ Relationship to Patient:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone Numbers: Home:_____ Work:_____ Cell:_____

PRIVACY PRACTICES (HIPAA)
By signing below I acknowledge that I was provided with the Notice of Privacy Practices of Grove Medical Associates, Inc.

Please list any persons to whom your protected health information can be disclosed *(e.g., spouse, parent, etc.). This list should include your emergency contact person.*
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Signature of patient/legally responsible party _____ **Date:** _____
Printed name of legally responsible party _____