☐ HIGHLAND CLINIC

A PROFESSIONAL MEDICAL CORPORATION

HC31

✱ Physician / Provider being seen today _____

✱ Referred By _____

✱ Primary Care Physician _____

PATIENT (person being seen today)

LAST NAME | FIRST | MIDDLE | (MAIDEN) | ☐ Sr ☐ Jr ☐ DDS ☐ III ☐ MD ☐ Rev

SOCIAL SECURITY NO. | BIRTH DATE | AGE | ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ MARRIED | SEX ☐ MALE ☐ FEMALE

RACE: ☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE OR CAUCASIAN ☐ NATIVE HAWAIIAN ☐ DECLINED

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NON-HISPANIC OR NON-LATINO ☐ DECLINED

PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ VIETNAMESE ☐ OTHER

MAILING ADDRESS | CITY/STATE | ZIP | HOME PHONE NUMBER ( )

BILLING ADDRESS (GUAR ALTERNATE ADDRESS) | CITY/STATE | ZIP | ***E-MAIL ADDRESS***

EMPLOYER NAME | EMPLOYER PHONE NUMBER ( ) | CELL PHONE NUMBER ( )

NAME OF SPOUSE | SPOUSE BIRTH DATE | SPOUSE SOCIAL SEC. NO.

NAME OF SPOUSE EMPLOYER | SPOUSE EMPLOYER PHONE NUMBER | CELL PHONE NUMBER ( )

NAME OF EMERGENCY CONTACT NOT LIVING WITH YOU | PHONE NUMBER | RELATIONSHIP TO PATIENT

IF PATIENT IS UNDER 18, PERSON RESPONSIBLE FOR PAYMENT (MUST BE PRESENT)

LAST NAME | FIRST | MIDDLE | (MAIDEN) | ☐ Sr ☐ Jr ☐ DDS ☐ III ☐ MD ☐ Rev

SOCIAL SECURITY NO. | BIRTHDATE | AGE | SEX ☐ MALE ☐ FEMALE | ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ MARRIED

RACE: ☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE OR CAUCASIAN ☐ NATIVE HAWAIIAN ☐ DECLINED

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NON-HISPANIC OR NON-LATINO ☐ DECLINED

PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ VIETNAMESE ☐ OTHER

BILLING ADDRESS | CITY/STATE | ZIP | PHONE NUMBER

EMPLOYER | PHONE NUMBER | CELL PHONE NUMBER ( )

INSURANCE INFORMATION

Do you have health insurance? ☐ YES ☐ NO

SUBSCRIBER (who carries the insurance) ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER _____ | SUBSCRIBER NAME (Primary Policy Holder) | SUBSCRIBER BIRTH DATE

NAME OF INSURANCE COMPANY

☐ MEDICARE ☐ AETNA ☐ TRICARE ☐ PRIMARY

☐ BLUE CROSS ☐ UNITED HEALTHCARE ☐ OTHER _____ ☐ SECONDARY

POLICY NUMBER | GROUP NUMBER | SUBSCRIBER EMPLOYER

FOR CLINIC USE ONLY

ACCOUNT NO.	PATIENT NO.	FIN CLASS	DATE	INFO TAKEN BY

I declare that the above answers and statements are true and correct to the best of my knowledge and belief. I hereby acknowledge that I have read this entire section, front and reverse, a nd agree to all of the terms herein and further acknowledge receipt of copy of this form with full disclosure statement.

_____ DATE

X _____ SIGNATURE