



In Home Primary Care, PLLC
127 Ave A Bay 3 Suite 1&2
Snohomish, WA 98290
Ph: (360) 863-3657 Fax: (360) 863-6295

PATIENT INFORMATION FORM

Patient Name: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Social Security Number: _____

Address (Where Patient resides): _____

City/state/zip: _____

Phone: _____ Fax: _____

Facility Name (if applicable): _____

Primary Insurance: _____ I.D. # _____

(Please include a copy of card)

Secondary Insurance: _____ I.D. # _____

(Please include a copy of card)

PLEASE INFORM US OF ANY INSURANCE CHANGES

That May Occur in The Future!

If Durable Power of Attorney in place, Please enter information below, If not Please enter Emergency contact.

Emergency Contact DPOA (Durable Power Of Attorney) Contact POA Contact

Name _____ Relationship _____

Address _____

Phone # _____ work phone # _____ cell or pager # _____

Please include a copy of the DPOA or POA document (this is required for accessing medical records from other providers)

*I give my consent for In Home Primary Care, PLLC to provide care considered necessary and proper in diagnosing and treating a physical and/or mental condition.

*I acknowledge receipt of In Home Primary Care's Privacy Policy.

I hereby assign the attending provider any money payable to me under my insurance coverage, and/or other arrangements with third parties, for payment of such services. I also authorize the attending provider to furnish my insurance company the medical information requested. I agree to be responsible for any testing or treatment that may not be considered by my insurance company to be medically necessary.

Signature: _____ Date: _____

If other than patient, note relationship: _____