RALEIGH ENDOCRINE ASSOCIATES

Today's Date ____/_____/_____ Chart No. ________________________

Full Legal Name ____ Date of Birth _____/_____/______

Preferred Name ____ Social Security Number: _______-______-__________

Mailing Address ____ Bldg/Unit/Apt#__________

City ____ State ______________________ Zip Code _________________

Email Address____

Legal Sex: ☐ Female ☐ Male Preferred Phone: ☐ Home ☐ Cell ☐ Work ☐ Other: (_____) - ______ - _______

Home Phone (______) - ______ - _______ Cell Phone (_____) - ______ - _______ Work Phone (_____) -______ - _______

Preferred Language: ____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ Caucasian/White ☐ Black/African American ☐ Asian ☐ Hawaiian or other Pacific Islander
☐ American Indian or Alaska Native ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner ☐ Other

Name of Parent / Legal Guardian with whom the patient resides (if applicable) ____

Student Status: ☐ Full-Time ☐ Part-Time ☐ Not a Student

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not employed ☐ Self-employed ☐ Retired ☐ Military Duty

Employer ____ Employer Phone _________________________________

Employer Address ____

Emergency Contact ____ Relationship________________________

Address____

Home Phone (______) - ______ - _______ Cell Phone (_____) - ______ - _______ Work Phone (_____) -______ - _______

Referring Physician ____ Phone No. ________________________________

Address ____ City _________________________ State________________

Primary Care Physician ____ Phone No. ________________________________

Address ____ City _________________________ State ________________

Pharmacy ____ Phone No. ________________________________

Address ____ City _________________________ State ________________

RALEIGH ENDOCRINE ASSOCIATES

Patient Full Name ____ Chart No. ______________________

Insurance Coverage Information- Primary:

Insurance Name ____

Insurance ID, Policy # or Certificate #: ____ Suffix: ____________

Group / Plan Name _________________________________ Group / Plan No. _______________________________

Effective Date(s) ________________________Insurance Claims Phone No. ____________________________________

Subscriber or Policy Holder Name ____

Subscriber Date of Birth _____/_____/______ Relationship to Patient __________________ Employer _______________

Subscriber Address ____

Insurance Coverage Information- Secondary:

Insurance Name ____

Insurance ID, Policy # or Certificate #: ____ Suffix: ____________

Group / Plan Name _________________________________ Group / Plan No. _______________________________

Effective Date(s) ________________________Insurance Claims Phone No. ____________________________________

Subscriber or Policy Holder Name ____

Subscriber Date of Birth _____/_____/______ Relationship to Patient __________________ Employer _______________

Subscriber Address ____

Insurance Coverage Information- Tertiary:

Insurance Name ____

Insurance ID, Policy # or Certificate #: ____ Suffix: ____________

Group / Plan Name _________________________________ Group / Plan No. _______________________________

Effective Date(s) ________________________Insurance Claims Phone No. ____________________________________

Subscriber or Policy Holder Name ____

Subscriber Date of Birth _____/_____/______ Relationship to Patient __________________ Employer _______________

Subscriber Address ____

The information which I have provided is true and complete to the best of my knowledge. I authorize Raleigh Endocrine Associates to bill my insurance company directly. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Raleigh Endocrine Associates and myself.

Signature ____ Date _____/_____/_____