PCA Primary Care Associates
A Concentra Affiliate

2019 Primary Care Associates
PATIENT INFORMATION

Please Print

Patient Information: [ ] Adult [ ] Child Date:_____

Last Name:_____First Name:_____MI:_____DOB:_____

[ ] Male [ ] Female [ ] Married [ ] Single [ ] Other SSN:_____

Race: []American Indian/AkNative []Asian []African American []Hawaiian/Pacific Islander []White []Unknown

Ethnicity: [] Hispanic or Latino [] Not Hispanic or Latino []Unknown []Declined

Mailing Address:_____

City:_____ State:_____Zip Code:_____

Phone:Home:_____Work:_____Cell:_____Primary:_____

Preferred Communication: []Home []Work []Cell

Employer:_____[]Full time []Part time Occupation:_____Phone:_____

Associated Party Name (Person Responsible for Account)

[]Self []Other Name:_____

Relationship: _____

Preferred Pharmacy Name:_____Street:_____City:_____

Insurance coverage	Primary Insurance	Secondary Insurance:
Name of Insurance Company:	_____	_____
Policy Holder:	_____	_____
Relationship to Insured:	[] Self [] Spouse [] Child [] Other	[] Self [] Spouse [] Child [] Other
Policy Number:	_____	_____
Group Number:	_____	_____

Individual(s) you would like to authorize release of your medical information. List name below:

Name:_____Relationship:_____

Name:_____Relationship:_____

This information is necessary for our courtesy billing to your insurance company. We can NEVER guarantee payment by your insurance company. The insurance company's contract is with you and your employer.

In case of emergency notify:_____ Phone:_____

Nearest relative or friend not living with you:_____ Phone:_____

Your Signature or (Parent or Guardian) :_____ Date:_____

Any Subsequent Insurance Changes must be Provided Prior to Any Office Visit ~Or~ Lab Testing. Thank You!