Saginaw Valley Family Care
5200 State St.
Saginaw, MI 48603
P: 989-793-4250 F: 989-793-6880

PLEASE BE SURE TO COMPLETE ALL ATTACHED PAGES

PATIENT INFORMATION_____**(Please Print)**_

Patient's Name_____

Address_____

City,State,Zip_____

Home Phone_____ **Cell #**_____**Work #**_____**Ext.**_____

Race ____Asian ____Black ____White ____Hispanic ____Native ____American/Eskimo ____Other

Ethnicity _____Hispanic or Latino _____Not Hispanic **Language** _____English _____Spanish
Gender: Male: _____ Female: _____Preferred: _____

SSN_____ **Date of Birth** MM/DD/YYYY_____

E-Mail Address_____

Employer Name_____

Employment Status_____Full-Time_____Part-Time_____Unemployed_____Self-Employed_____Retired

Marital Status _____ Single _____Married _____Widowed _____Divorced

Name of Spouse_____**Phone**_____**D.O.B.**_____

Emergency Contact_____**Relationship**_____
Home Phone _____**Cell #**_____**Work #**_____**D.O.B**._____

Emergency Contact_____**Relationship**_____
Home Phone_____ **Cell #**_____**Work #**_____**D.O.B**._____

PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVERS LICENSE AT THE FRONT DESK

Saginaw Valley Family Care participates with a variety of health care plans (contact your insurance company directly to see if we partner with your insurance plan). As a courtesy to our patients, our office will submit claims to all carriers, regardless of our participation status with them. Patients are responsible for paying any applicable co-pay and deductible amounts on the day the service is rendered or paying in full if we do not participate with your health care plan.

I understand that my insurance policy is a contract between myself and my insurance company. Therefore, I am responsible for all fees regardless of insurance coverage at the time services are rendered. I agree to be financially responsible for all costs incurred in connection with medical examinations, treatments, referrals, testing and/or procedures ordered by this office, whether conducted in this office or elsewhere which are not otherwise paid by my insurance.

Some information contained in my patients record are necessary for the payment of insurance benefits without regard to any limitation placed on dates, history of illness or diagnostic and therapeutic information. I hereby authorize Saginaw Valley Family Care or its designee to bill and release to my insurance company and/or third party payer(s) and/or external review agency.

Guarantor Signature_____ Date_____

(Responsible Party)