Mending Hearts Primary Care, LLC

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Phone: (813)-278-1241 Fax (833)-450-5156

NEW PATIENT FORM

PLEASE DO NOT LEAVE ANY BLANK LINES **DATE:** _____/ _____/_____

Patient's name: _____ **Birth Date:** _____ **Age:** ___

Social Security Number: _____ **Sex:** □ **M** □ **F** **Marital Status**_____

Home Address: _____
(street number/name) **(city)** **(state)** **(zip)**

Race (please check one): □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ Caucasian/White □ Multiracial □ Refused/Declined

Ethnicity (please check one) □ Hispanic or Latino □ Not Hispanic or Latino □ Refused/Declined

Preferred Language: □ English □ Spanish □ Other _____

Spouse's name: _____ **Birth Date:** _____

Phone Number (home):_____ **Cell Phone:**_____

May we leave a detailed message on your answering machine, voicemail or cellphone regarding personal health information verifying appointment times, or to change an appointment? □ No □ Yes

May we leave a detailed message with another family member in your household regarding personal health information, verifying appointments, or to change an appointment? □ No □ Yes

Appt Reminders □ Phone Call □ Text □ Email

In case of emergency/Alternate contact/phone number: _____

Are you a resident of: □**Nursing Home** □**Assisted Living Facility** □**Independent Living** □**Group Home**

Name/Phone_____**Manager of Residence**_____

Patient portal: □ No □ Yes
If Yes Sign up Via □ **Text** □ **Email**
Email: _____

Do you have a Dog: □ **Yes** □ **No**

INSURANCE INFORMATION

Primary Insurance: _____ **Copay Amount** _____

Policy #: _____ **Group #:** _____

Subscriber: _____

Subscriber's date of birth: _____ **Subscriber's SSN:** _____

Subscriber's employer: _____

Subscriber's address: _____

(street number/name) (city) (state) (zip)

Secondary Insurance: _____ **Copay Amount** _____

Policy #: _____ **Group #:** _____

Subscriber: _____

Subscriber's date of birth: _____ **Subscriber's SSN:** _____

Subscriber's employer: _____

Subscriber's address: _____

(street number/name) (city) (state) (zip)

Pharmacy-Local: _____ **Phone:** _____

Address: _____

Pharmacy-Mail Order: _____ **Phone:** _____

Address: _____

PLEASE HAVE YOUR INSURANCE CARDS AVAILABLE FOR PHOTOCOPYING. ALL CHARGES ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.