Please print all information and use legal name printed on your insurance card

Who is responsible for patient? Self ____ Parent____ Spouse_____ Legal Guardian_____

Legal Name _____

Mothers Name (minor patient) _____ Fathers name (minor patient) _____

Address _____
Street Apt City State zip code

Date of Birth____/____/_____ **Sex** Male____ Female____ **Marital Status** Single____ Married____ Divorced____ Widowed____

Home Phone # _____(____) **Cell Phone#**_____ (____)

Work phone#_____(____) ***Please designate preferred contact number with an (X)***

Is it okay to leave a detailed message on (preferred contact number) voicemail? _____Y_____N

Do you have a **Living Will or Medical Advance Directive** (circle) Yes No

(If you answered yes, please provide a copy to staff for your medical record)

Employment Status: Full-Time _____ Part-Time _____

Unemployed (choose one) Retired_____ Disabled _____ Student_____ Full-Time( )/ Part-Time( ) Other _____

Emergency contact_____Phone#_____Relationship_____

Patient Email Address_____

Race (may circle more than 1) Black/African-American White/Caucasian Native Hawaiian/other Pacific Islander
American Indian/Alaska Native Hispanic Asian Other Decline/Unknown

Ethnicity (circle one) Hispanic Non-Hispanic Decline/Unknown

Preferred Language_____ Interpreter requested? Y_____ N_____

Disability Hearing _____Visual _____ Physical _____ Intellectual/Cognitive_____

Accommodations needed (Please explain)_____

Patient Occupation_____

Preferred Pharmacy (name and location) _____ **Phone#**_____

Cancellation Policy

I have read and understand Doylestown Family Medicine's cancellation policy

Signature_____ Date_____

Insurance Information

Primary Insurance

Subscriber name _____ Date of Birth___/___/___

Relation to patient_____ Insurance Carrier_____

Policy/ID Number_____ Group number_____

Secondary Insurance

Subscriber name_____ Date of Birth____/____/____

Relation to patient_____ Insurance Carrier_____

Policy/ID number _____ Group number_____

Patient Centered Medical Home (PCMH) Philosophy

Providing care that is respectful and responsive to individual patient preferences, needs, and values and ensuring that patient values guide clinical decisions.

A Patient Centered Medical Home is called a "home" because we would like it to be the first place you think of for all of your (non-emergent) medical needs. Much like a home, the goal is to make it easy and comfortable for you to get the care you need, in a way that works best for you. Within our patient centered medical home, a partnership develops between you and your healthcare team in order to coordinate the services you need, and to provide you with the best care possible.

In your patient packet you'll find more detailed information about the PCMH partnership, including what you can expect from our team and our expectations of you and your family. We encourage you to discuss PCMH with our staff. We will be happy to answer your questions.

PCMH Orientation Packet received

Signature _____ **Date** _____

Authorization for Treatment

I hereby authorize Dr. Schnur and Doylestown Family Medicine (DFM) to release any medical information or other information required in the course of examination and treatment. I authorize payment directly to Doylestown Family Medicine any charges due for services rendered. I recognize and accept financial responsibility for services rendered regardless of insurance coverage and agree to pay for any non-covered services, co-pays, co-insurance, and deductibles.

The medical providers at DFM will perform/order only those examinations, tests, and treatments that are medically necessary. It is my responsibility to determine if my insurance will cover these medical interventions. I authorize the office to use Fax and Email as a means to of rapid communication with other physician's offices, pharmacies, laboratories and insurance companies that are pertinent to my care. I understand that this office follows HIPAA protocols and protects my privacy as a patient.

I have read and understand these statements.

Patient or Parent/Guardian signature_____ **Date**_____