Horizon Care
MEDICAL GROUP

Patient Information sheet (Please circle)

RESPONSIBLE PARTY INFORMATION (Must be over 18 years and/or Legal Guardian)

Self/Parent/Guardian: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Patient E-mail Address: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Employer's Name: _____ Phone: _____

DEPENDANT/PATIENT INFORMATION:

First Name	MI	Legal Last Name	Sex M/F	Birth Date	Insurance Type: Primary/ Secondary		Relation

INSURANCE INFORMATION (Subscriber Info): A photo ID and Insurance card must be presented at each visit.

Insurance Type: _____

Subscriber's Name: _____ DOB: _____

Phone Number: _____

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Subscriber's Address- if different than above: _____

_____

Subscriber's Employer: _____

If not through an employer, please check box:

□ State Insurance (Medicaid) □ Government (Medicare) □ Self Purchased Policy- Not through a business

Do you have a secondary insurance? If yes, please fill out this section.

Insurance Type: _____
Subscriber's Name: _____ DOB: _____
Phone Number: _____
Subscriber's Address- if different than above: _____
_____
Subscriber's Employer: _____
If not through an employer, please check box:
□ State Insurance (Medicaid) □ Government (Medicare) □ Self Purchased Policy- Not through a business

Do you have a third insurance? If yes, please fill out this section.

Insurance Type: _____
Subscriber's Name: _____ DOB: _____
Phone Number: _____
Subscriber's Address- if different than above: _____
_____
Subscriber's Employer: _____
If not through an employer, please check box:
□ State Insurance (Medicaid) □ Government (Medicare) □ Self Purchased Policy- Not through a business