Tri-County Internal Medicine & Family Practice
7284 SW SR 26 Trenton, FL 32693

Patient Forms

Basic Information

Full Name:
First ___________________________ Middle ________________ Last_________________________

Sex: ( ) Male ( ) Female ( ) Unknown

Date of Birth: ___________________________

Primary Phone: ( ) Home ( ) Mobile ( ) Work

Phone number___________________________

Email: ________________________________

Social Security Number: __________________

Address: _______________________________
____
____

Marital Status: __________________________

Driver's License State: ___________

Driver's License # _________________________

Demographics

Sexual Orientation __________________

Gender Identity ________________________

Hispanic or Latino? ( ) Yes ( ) No

Ethnicity: _____________________________

Race: __________________

Language: _____________________________

Emergency Contact

Relationship to Contact: __________________________________

Full Name: ____
First *Middle* *Last*

Primary Phone Number: ( ) Home ( ) Mobile ( ) Work __________________________________

Email: _____________________________________

Address: ___________________________________
____
____

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Financial Information

Responsible Party

Who will be financially responsible for you? ( ) Myself ( ) Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Patient? ____

Full Name: ____
First *Middle* *Last*

Primary Phone Number: ( ) Home ( ) Mobile ( ) Work _________________________________

Method of Payment

What will be your method of payment? ( ) Insurance ( ) Self-Pay

If you chose "Insurance", please fill out the following:

Primary Insurance Policy

Insurance Company __________________________ **Policy Number** ______________________

Insurance Plan ____________________ **Insurance Phone #** ____________________
Group Number _____________________

Insurance Company Address _______________________________
____
____

Relationship to Primary Policy Holder? ___________________________

If you are not the primary policy holder, please fill out the following:

Full Name ____
First Middle Last

Sex: ( ) Male ( ) Female ( ) Unknown **Date of Birth:** ___________________________

Policy ID Number _____________________ **Social Security #** _____________________

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Policy Holder's Address: ________________________________
____
____

Secondary Insurance

If you do not have a secondary insurance policy, you can leave this section blank.

Insurance Company ___________________________ **Policy Number** __________________

Insurance Plan _____________________ **Insurance Phone #** _____________________

Group Number ______________________

Insurance Company Address ________________________________
____
____

Relationship to Primary Policy Holder? ____________________________

If you are not the secondary policy holder, please fill out the following:

Full Name ____
First Middle Last

Sex: ( ) Male ( ) Female ( ) Unknown **Date of Birth:** ____________________________

Policy ID Number ______________________ **Social Security #** ______________________

Policy Holder's Address: ________________________________
____
____

Additional Information

How did you hear about us?

____

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address