



Horizon Health Center, Inc.

Today's date _____ How did you hear about HHC: Friend Media Referral
Patient Name _____ Date of birth _____ Age _____ Male Female
Home Phone (_____) _____ Street Address _____
City _____ State _____ Zip code _____ Social Security # _____
Marital status S M W D (circle one) Work phone (_____) _____ Cell phone (_____) _____
E-mail address: _____ Family-size: _____
Income: \$ _____ weekly bi-weekly monthly annually
Employer _____ Occupation _____
Veteran: Please select one: Yes No Active
If married, spouse's name (if minor, parents' names) _____ Date of birth _____
Work phone _____ Employer _____ Occupation _____
Emergency contact name, relationship, & phone # of someone not living with you _____

Preferred Method of Contact: Mail Text/SMS Email Phone (circle one)
Do you have a Living Will: Yes No Elect to utilize HHC's Standard Living Will?
Race: Asian American Indian/Alaskan Native Black or African-American Caucasian/White
 Hawaiian Native Mixed (more than one) Other _____ Do not wish to answer
I identify as: Hispanic Non-Hispanic

Insurance Information

Primary insurance _____ PPO ___ HMO ___ Phone number (_____) _____
Subscriber name _____ Date of birth _____
Subscriber Social Security # _____ Employer _____
Identification number _____ Group number _____
Secondary insurance _____ PPO ___ HMO ___ Phone number (_____) _____
Subscriber name _____ Date of birth _____
Subscriber social security # _____ Employer _____
Identification number _____ Group number _____

NO Insurance: Self-Pay – Fee Options Needed _____ Yes _____ No
Is this visit a worker's compensation claim? Yes No Contact person & phone # _____
Is this visit related to an accident? Yes No (if yes, please fill out an Accident Form) see attached

Your insurance company has asked that any co-payment be paid at the time of service. You may pay with a personal check, cash, VISA or MasterCard Debit/Credit. If your insurance company requires referrals, we will need your referral prior to being seen. By signing below, you hereby authorize Horizon Health Center to file your insurance claim for the services received in the office and/or hospital from any physician in this group. You authorize us to send any medical information needed to process your claim. You also authorize payment on your behalf be made to Horizon Health Center Thank you.

Signature (if minor, parent's signature) _____ Date _____