PATIENT INFORMATION FORM

Welcome to Coia Comprehensive Primary Care, LLC

Please provide the following information

Today's Date:_____

PATIENT INFORMATION

Last Name:	First Name:	Middle:	Date of Birth: / /	Age:	Sex:
Address:	City:	State:	Zip Code:		
Social Security #:	Home phone #: ( )	Cell phone #: ( )	May we send appointment reminders via text and voicemail? Yes. / No		
Email Address:	Employer or School Name:				
Street Address:	City:	State:	Zip Code:		
If Minor, Name of Parent or Guardian	Preferred Language (If other than English)				
Race: (circle one) White	Black/African American	Asian	American Indian	Unknown	Other _____ Decline
Ethnicity (circle one): Hispanic	Non-Hispanic	Unknown			
Marital status: ___ Single	___ Married	___ Widowed	___ Divorced	___ Separated	
Spouse/Partner's Name:	Phone #:				
In Case of Emergency Notify:	Relation:	Phone #:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Date of Birth:	Address (if different):	Home phone #:
Occupation:	Employer:	Employer address:	Employer phone #:

Please indicate **Primary** insurance company:

Subscriber's name:	Subscriber's S.S. #:	Date of Birth:	Group #:	Policy #:

Patient's relationship to subscriber: Circle (self) or Name of other: Relationship to subscriber:

Please indicate **Secondary** insurance com: (if applicable)

Subscriber's Name:	Subscriber's S.S. #:	Date of Birth:	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber: Circle (self) or Name of other: Relationship to subscriber:

PHARMACY INFORMATION

Name:	Phone:		
Street Address:	City:	State:	Zip

PREVIOUS MEDICAL PROVIDER

Name/First:	Last:	Practice Name:		
Street Address:		City:	State:	Zip
Phone:	Fax:	Email:		

712 Oaklawn Avenue, Suite 201, Cranston, RI 02920

Tel: 401-944-0044 | Fax: 401-654-5335 | www.coiaprimarycare.com