Steven A. Crews, DO, PA Family Practice 352-360-0654 www.crewsfamilypractice.com DATE :_____

Last Name		Date of Birth	
First Name	MI	Sex: Male	Female
Address		Marital Status	
		Social Security #	
City		Employer Name	
State		Employment Status (FT,PT, retired)	
Zip		Student Status (FT,PT)	
Home Phone		REQUIRED for Meaningful use	
Work Phone	Extension	Race: White African American Hispanic Other Refuse	
Cell Phone		Ethnicity: Hispanic or Latin Non Hispanic or black Refuse	
		Advanced Directives: LIV WILL Health Surrogate Other	

Responsible Party (if different from above or insurance is through another person)		Emergency Contact: (not a spouse)	
Last Name		Last Name	
First Name		First Name	
Middle Initial		Relation	
DOB		Address	
Social Security #		City	
Gender	Male Female	State	
Phone		Zip	
Relation		Home Phone	
Address		Work Phone	

Insurance

My insurance coverage is plan is from the ACA exchange? YES NO

Primary Insurance		Secondary Insurance	
Insurance Address		Insurance Address	
City		City	
State		State	
Zip		Zip	
Phone		Phone	
Subscriber #		Subscriber #	
Co-pay amount		Co-pay amount	
Insured Name		Insured Name	
Relationship		Relationship	
Group Number		Group Number	

Please Complete RESPONSIBLE PARTY SECTION if any of the above INSURED Is different than the patient

We do not accept MEDICAID and cannot see any MEDICARE Patients with MEDICAID Secondary.

By signing below, I attest that I do not have Medicaid and acknowledge that if I do start to receive benefits from Medicaid that I will notify the office and will not be able to continue to see Dr. Steven A Crews for my medical care and will need to find another provider.

Name: _____ Date: _____

Updated 03/09/2016