GARDEN CITY
MEDICAL CENTER, P.C.
Pediatrics • Family Practice • Geriatrics • Urgent Care

2020 MIDDLEBELT RD • GARDEN CITY • MI • 48135 ph: 734.522.3770 • fx: 734.522.6114

PATIENT INFORMATION *(PLEASE PRINT)*

Patient's Name: _____ Advance Directive Information: YES [ ] NO [ ]

_____
Street Address City State Zip

Phone (Home): _____ (Cell): _____

Social Security #: _____

Age: _____ Birthdate: _____ Sex: M [ ] F [ ]

Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated [ ]

Referred by: _____

PREFERRED PHARMACY:

Pharmacy Name: _____ *Phone:* _____

Address: _____

ALLERGIES TO MEDICATIONS *(PLEASE LIST):*

_____

_____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name: _____ Relationship: _____

_____
Street Address City State Zip

Phone: _____

INSURED PERSONS INFORMATION

GUARDIAN / SPOUSE / PARENT (If child is under 18) / RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT:

Dependent [ ] Mother [ ] Father [ ] Spouse [ ] Guardian [ ] Other [ ]

Name: _____

_____
Street Address City State Zip

Birth Date: _____

Social Security #: _____

Home Phone: _____

Employer's Name: _____

_____
Street Address City State Zip

Occupation: _____

Business Phone: _____

Signature: _____ Date: _____

– *FOR OFFICE USE ONLY* –

PRIMARY INSURANCE

BLUE CROSS BLUE SHIELD

Subscriber Name: _____
Subscriber ID: _____
Group: _____
Service Code: _____

MEDICARE #: _____

Subscriber Name: _____
Subscriber ID: _____
Group: _____
Service Code: _____

MEDICAID #: _____

Subscriber Name: _____
Subscriber ID: _____
Group: _____
Service Code: _____

OTHER #: _____

Subscriber Name: _____
Subscriber ID: _____
Group: _____
Service Code: _____

AUTO INJURY

Injury Date: _____
Injury Type: _____
Claim #: _____
Insurance Co. Name #: _____
Adjuster Name: _____
Street Address, City, State and Zip: _____

_____
Phone: _____

WORK INJURY

Injury Date: _____
Injury Type: _____
Claim #: _____
Name of Employer: _____
Street Address, City, State and Zip: _____

_____
Phone: _____