REFLEX CONFIDENTIAL PERSONAL INFORMATION FORM

Welcome to Reflex! In order to best serve you please complete the following in as much detail as possible.

Last Name:_________________________ First Name:________________________ Middle Initial:________________

Last Four Digits of your SSN (Required for billing & insurance processing):_________________

Preferred Name: ___________________________ Age:_________ Date of Birth:____/____/____/

Gender:
❐ Male
❐ Female
❐ Other

Relationship Status:
❐ Single
❐ Married
❐ Other

Ethnicity:
❐ Non-Hispanic or Latino
❐ Hispanic or Latino
❐ Mexican American
❐ Cuban
❐ Puerto Rican

Race:
❐ White
❐ Asian
❐ Samoan
❐ Pacific Islander
❐ Other___________________________
❐ Black or African American
❐ American Indian/Alaska Native
❐ Native Hawaiian

Preferred Language:
❐ English
❐ Spanish
❐ Other_____________________

Address:______________________________ City:____________________ State:_____________ Zip Code:____________

Telephone # (__________)_____________(Cell) (________)____________(Work/Home)

E-mail Address: __________________________________ Preferred Method of Contact: ❐ Phone ❐ E-mail

Emergency Contact: ______________________________(Name/Relationship) **Phone**: (__________)____________

How do you like to be reminded of appointments? ❐ Phone Call ❐ Text Message ❐ Email

Insurance Information

Please provide our Patient Care Coordinator with your insurance card(s) so that we make keep a photocopy on file

Primary Insurance Co: _____________________________ Policy Holder's Name: _____________________

Relationship to Insured (check one): ___________(Self) _______(Spouse) _______(Child) _(Other)

Subscriber/Member ID#:____________________________ Group#:____

Secondary Insurance Co:___________________________ Policy Holder's Name:______________________

Relationship to Insured (check one): ___________(Self) _______(Spouse) _______(Child) _(Other)

Subscriber/Member ID#: ___________________________ Group#:____

Are you 'Medicare Working Age' (on Medicare but still working) ❐Yes ❐No

By Signing Below, I verify that all of the above information is correct and true to the best of my knowledge.

____ _________________________________

Patient/Authorized Individuals Signature Date