

# Sparks Family Medicine, Ltd.

653 Town Center Drive, Suite 514 (702) 243-2689 Phone  
Las Vegas, Nevada 89144 (702) 243-2632 Fax

Please print legibly to complete all applicable fields

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ SS # \_\_\_\_\_  
Last First MI

Birth Date \_\_\_\_\_ Age \_\_\_\_ Sex M \_\_\_ F \_\_\_ Marital Status S \_\_\_ M \_\_\_ W \_\_\_ D \_\_\_

Address \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Street Apt # City State Zip Code Home Phone #

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Work Phone #

Emergency Contact Not Living With You \_\_\_\_\_ Relation \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Referred by: Provider List \_\_\_ Ad \_\_\_ Relative\Friend \_\_\_ Other \_\_\_ Referred by Dr. \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_ Ins. Co. Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender M \_\_\_ F \_\_\_  
Last First MI

Insurance Co Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

SS # or ID # \_\_\_\_\_ Group # \_\_\_\_\_ Ins Plan Name \_\_\_\_\_

Employer \_\_\_\_\_ Patient's Relationship to Insured Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Ins. Co. Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender M \_\_\_ F \_\_\_  
Last First MI

Insurance Co Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

SS # or ID # \_\_\_\_\_ Group # \_\_\_\_\_ Ins Plan Name \_\_\_\_\_

Employer \_\_\_\_\_ Patient's Relationship to Insured Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_

## Please have insurance card(s) and ID Available for Copying

I hereby voluntarily consent to care at Sparks Family Medicine, Ltd. encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing and administration of medications prescribed by the physician. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, physicians' assistants, medical assistants, or their designees as is necessary in the medical staff's judgment.

Payment for these services is expected at the time services are rendered. If Sparks Family Medicine, Ltd. providers are contracted providers for your insurance carrier, we are required by your insurance company to collect your financial portion at the time services are rendered. I hereby authorized my insurance carrier to pay medical benefits directly to Sparks Family Medicine, Ltd. I further authorize Sparks Family Medicine, Ltd. to release medical information in accordance with HIPAA.

I understand that I am financially responsible for all charges made to my account in accordance with Sparks Family Medicine's Financial Policy. A photocopy of this authorization is to be considered as valid as the original, until revoked by me in writing.

Signature \_\_\_\_\_  
Patient/Parent/Guardian

Date \_\_\_\_\_