UAMS **Fouke Health and Wellness Center**

Insurance Information

Primary Medical Insurance: _____

Group Number: _____ Insurance ID Number: _____

Patient's relationship to insured: Self Child Other: _____

Secondary Medical Insurance: _____

Group Number: _____ Insurance ID Number: _____

Primary Care Physician: _____

***Please provide a copy of your insurance card as well as a photo ID**

_____Complete this section if patient is a minor_____

Responsible Party: _____ Relation to Patient: _____

Birth Date: ____/____/____ Male/Female SSN: _____

Age: _____ Marital Status: Single Married Widowed Divorced

Spouse's Name: _____

Mailing Address (if different from patient):

_____

Street City State Zip

Employer: _____

Work Phone: _____