CASCADE HEMOPHILIA CONSORTIUM

Information Form for Adult Patients

Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone Number: _____

Primary Insurance Information (please complete this section or attach copy of both sides of insurance cards)

Insurance Company: _____ Phone Number: _____

Contract/Policy Number: _____ Group Number: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Employer: _____ Policy Holder's Date of Birth: _____

Prescription coverage?: _____ Covered by insurance listed above ____Separate Prescription Card ___ No Prescription Coverage

Secondary Insurance Information

Insurance Company: _____ Phone Number: _____

Contract/Policy Number: _____ Group Number: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Employer: _____ Policy Holder's Date of Birth: _____

Prescription coverage?: _____ Covered by insurance listed above ____Separate Prescription Card ___ No Prescription Coverage

Additional Insurance Information

If you have coverage with Medicaid or Children's Special Health Care Services, please list ID # _____

If you have coverage with Medicare, please list your Medicare Claim Number: _____

Patient Signature: _____ **Date**: _____

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