Form # PCC-1415-FFE
Orig 10/95 Rev 08/02

Patient Information Form

Elderton Primary Care Center *116 Main St. Box 148* *Elderton, PA 15736*	*Leechburg Primary Care Center* *116 Main St.* *Leechburg, PA 15656*	*Women's Health Care* *Medical Arts Building, Suite 540* *Kittanning, PA 16201*	*ABC Women's Care* *Medical Arts Building, Suite 300* *Kittanning, PA 16201*

Name ______________________ Soc Sec Number ______________ Date __________
Last First Middle

Marital Status __________ Birth Date ________ Age _____ yrs. Race __________

Legal Representative/Self ______________ Relationship to Patient ______________ Phone # __________

Allergies ______________________________ Advanced Directive ☐ Yes ☐ No

Medications ______________________________

Home Address:

Address ______________________________

City ______________________________

State ______________ Zip Code ______________

Phone Numbers:

Home ______________________________

Work ______________________________

Other ______________________________

Employer:

Name ______________________________

Address ______________________________

City ______________________________

State ______________ Zip Code ______________

Alternative Person to notify in an emergency:

Name ______________________________

Address ______________________________

City ______________________________

State ______________ Zip Code ______________

Relationship ______________________________

Phone # ______________________________

Insurance Information

Primary Insurance: ______________________________

ID # ______________________________

Group Number: ______________________________

Owner of Policy: ______________________________
(Please include middle initial)

DOB & Relationship: ______________________________

Policyholders employer: ______________________________

and Address: ______________________________

Secondary Insurance: ______________________________

ID # ______________________________

Group Number: ______________________________

Owner of Policy: ______________________________
(Please include middle initial)

DOB & Relationship: ______________________________

Policyholders employer: ______________________________

and Address: ______________________________