

**Bay Harbor Family Medicine  
333 State Street, Suite 204  
Erie, Pennsylvania 16507**

**Patient Name** \_\_\_\_\_ **Marital Status** \_\_\_\_\_ **Sex** \_\_\_\_\_

**Address** \_\_\_\_\_  
**Street City State Zipcode**

**Birthdate** \_\_\_\_\_ **SS#** \_\_\_\_\_ **Home Ph#** \_\_\_\_\_

**Cell Ph#:** \_\_\_\_\_

**Employer** \_\_\_\_\_ **Work Ph#** \_\_\_\_\_

**Spouse/Parent/Guardian** \_\_\_\_\_ **Home Ph#** \_\_\_\_\_  
(please circle)

**Work Ph#** \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**Emergency Contact Relationship: spouse/parent/friend/other** \_\_\_\_\_

**Primary Ins** \_\_\_\_\_ **ID#** \_\_\_\_\_

**Policyholder** \_\_\_\_\_ **Group#** \_\_\_\_\_

**Address(if different from above)** \_\_\_\_\_  
**Street City State Zipcode**

**Employer** \_\_\_\_\_ **Policyholder Birthdate** \_\_\_\_\_

**Secondary Ins** \_\_\_\_\_ **ID#** \_\_\_\_\_

**Policyholder** \_\_\_\_\_ **Group#** \_\_\_\_\_

**Employer** \_\_\_\_\_ **Policyholder Birthdate** \_\_\_\_\_

