TO PROCESS YOUR BILL CORRECTLY, WE ASK THAT YOU PLEASE FILL OUT ALL INFORMATION COMPLETELY

PATIENT INFORMATION

Patient Name: (L)_____(F)_____(M.I.)_____

Home Address: _____ _____ _____ _____

Street City State Zip Code

Phone: Hm:_____ Cell:_____ Social Security #:_____ _____ _____

Date of Birth: _____ Age:_____ Sex: _____ Marital Status:_____

Employer: _____Employer Phone #:_____

Preferred Pharmacy:_____

Name Address

RESPONSIBLE PARTY

Name: (L)_____(F)_____(M.I.)_____

Home Address: _____ _____ _____ _____

Street City State Zip Code

Phone: Hm:_____ Cell:_____ Social Security #:_____ _____ _____

Date of Birth: _____ Age:_____ Sex: _____ Marital Status:_____

Employer: _____Employer Phone #:_____

BILLING INFORMATION

☐ Self-Pay

☐ Workers Compensation

Company Name:_____

Authorized By:_____

Contact Phone #:_____

☐ Bill Insurance

Name of Insurance:_____ID#:_____Group #:_____

Subscriber Name:_____ Date of Birth:_____

Social Security #:_____ _____ _____ Relationship to Patient_____

Secondary Insurance Information:

Name of Insurance:_____ID#:_____Group #:_____

Subscriber Name:_____ Date of Birth:_____

Social Security #:_____ _____ _____ Relationship to Patient_____

MEDICAL INFORMATION

Family Physician:_____

Emergency Contact Name:_____ Phone #:_____

Known Drug Allergies:_____

How did you hear about us?_____

I have reviewed Minor Emergency and Family Care Center, Inc. Privacy Practice

_____**I understand that a copy will be provided to me at my request.**

INITIAL PLEASE

AUTHORIZATION AND ACKNOWLEDGEMENT: I agree to pay at the time of my service unless prior arrangement have been made. I authorize any necessary treatment by the physician and/or staff of Minor Emergency and Family Care Center, Inc. I agree to be a responsible for my dependents bills or mine and realize my insurance coverage does not relieve me of this responsibility. I authorize of any and all medical information to my insurance company or governmental agency (including Medicare) for third party reimbursement for treatment, payments, and operations. I hereby assign all insurance benefits to be paid to Minor Emergency and Family Care Center, Inc. and agree to pay all costs of collection action including 100% legal fees and 33 1/3% collection fees if I fail to pay my bill. Medical records for any other purpose will not be released without proper-signed authorization.

Signed: _____**Date:**_____