

PATIENT INFORMATION

Patient Name: _____

Address: _____

Street

City _____ State _____ Zip _____

E-MAIL: _____

Home Phone: _____

Cell Phone: _____

Social Security #: _____

Employer: _____

Work Phone: _____

Occupation: _____

Address: _____

Street

City _____ State _____ Zip _____

Date: _____

Birth Date: _____ Age: _____

Male Female Child

Single Married Divorced Widowed

Spouse Name: _____

Spouse Social Security #: _____

Spouse Work Phone: _____

Spouse Employer: _____

Address: _____

Street

City _____ State _____ Zip _____

If Under 18 Years of Age

Father/Guardian: _____

Empl: _____ Occup: _____

Address: _____

Work Phone: _____

Home Address: _____

Street

City _____ State _____ Zip _____

Father/Guardian SSN: _____

Person To Bill: _____

Mother/Guardian: _____

Empl: _____ Occup: _____

Address: _____

Work Phone: _____

Home Address: _____

Street

City _____ State _____ Zip _____

Mother/Guardian SSN: _____

Have you or any other family members been a patient here? Yes No Referred by: _____

Did you find us by: other patient friend brochure Yellow Pages ad employer

insurance list other Doctor drive-by medical exchange other

Did our extended hours influence your decision to come here? Yes No

Name and relationship of closest relatives (other than spouse): _____

Address: _____

Insurance Information

Primary Carrier: _____

Address to send claim: _____

Phone _____

ID/Policy # _____ Group # _____

Insured's Name _____

Secondary Carrier: _____

Address to send claim: _____

Phone _____

ID/Policy # _____ Group # _____

Insured's Name _____

I authorize Autumn Road Family Practice, P.A. to render medical services and release all medical records to my insurance carriers. I also assigned payment of all benefits to Autumn Road Family Practice, P.A. I understand that all charges on my responsibility and are payable within 45 days from date of service. If the account becomes delinquent there will be a statement perforation charge of \$4.00 added monthly.

Patient's Signature: _____ Date: _____

Insured's Signature: _____ Date: _____

A photocopy of this authorization and assignment shall be considered as valid as the original.