Myrtle Ridge Family Medicine

THANK YOU FOR CHOOSING OUR OFFICE. IN ORDER TO SERVE YOU PROPERLY WE ASK THAT YOU PROVIDE THE FOLLOWING INFORMATION. ALL INFORMATION WILL BE STRICTLY CONFIDENTIAL. (PLEASE PRINT)

PATIENT INFORMATION

DATE _____

PATIENT NAME | DATE OF BIRTH | M/F | SOCIAL SECURITY #

ADDRESS | CITY | STATE | ZIP | HOME PHONE (PATIENT)

SPOUSE (or PARENT, IF CHILD) | ADDRESS (IF DIFFERENT) | CELL PHONE (PATIENT)

EMPLOYER | ADDRESS | WORK PHONE (PATIENT)

EMERGENCY CONTACT

_____
EMAIL (PATIENT)

NAME | RELATIONSHIP | PHONE

INSURANCE INFORMATION

DO YOU HAVE HEALTH INSURANCE? Y / N
DO YOU INTEND TO PAY with CASH _____CREDIT CARD _____DEBIT CARD_____ (Sorry. We do not accept checks.)

1. INSURANCE COMPANY | GROUP POLICY # | INSURED'S ID #

1. INSURANCE COMPANY ADDRESS | PHONE #

1. POLICY HOLDER'S NAME | DOB | SOC SEC # | INSURED's RELATIONSHIP TO PATIENT

2. SECONDARY INSURANCE COMPANY | GROUP POLICY # | INSURED'S ID #

2. SECONDARY INSURANCE COMPANY ADDRESS | PHONE #

2. SECONDARY INSURANCE POLICY HOLDER'S NAME | DOB | SOC SEC # | INSURED's RELATIONSHIP TO PATIENT

HOW DID YOU HEAR ABOUT OUR OFFICE? | DO YOU HAVE A LIVING WILL? | WOULD YOU LIKE ONE?