

Patient Information (Please Print)

Name: _____ SS#: _____
Street Address: _____ P.O. Box #: _____
City, State, Zip: _____ Home Phone #: _____
Gender: Male/Female Birthdate: _____ Cell Phone #: _____
Previous Name (s): _____
Name of Insurance: _____ Card Copied: Yes or No

Responsible Party (only if other than self)

Name: _____ Home Phone #: _____
Street Address: _____ P.O. Box #: _____
City, State, Zip: _____ Birthdate: _____
Relationship to Patient: Spouse Parent Other _____
Employer: _____ Work Phone #: _____

Employer/School Information

Employer/School: _____
Street Address: _____ P.O. Box #: _____
City, State, Zip: _____ Phone #: _____
If work related injury, contact person: _____

Emergency Contact (relative outside of home)

Name: _____ Relationship: _____
Street Address: _____ P.O. Box #: _____
City, State, Zip: _____ Phone #: _____

Acknowledgement of Receipt of Privacy Notice

I understand that I have access to Family Medical Center, P.C. Notice of Privacy Practices and may request a copy at anytime.

Signature: _____ Date: _____

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. **Payment is required for all services at the time they are rendered.** We accept payment in the form of cash, credit card or check. Our office will file with the appropriate insurance. However, you will be asked to pay any unmet deductible, non-covered services and co-payments. Your signature below signifies your understanding and willingness to comply with this policy.

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician.

Signature: _____ Date: _____