NAME _____ Birthdate _____

_____
street city state zip

Phone (_____) _____ SS# _____ e-mail address _____

EMPLOYMENT / INSURANCE INFORMATION

Job description _____ Job title _____

_____
street city state zip

INSURANCE COMPANY'S PROGRAM YOU SELECTED _____

If pre-authorization required please list phone number (_____)_____ Policy #_____ Group # _____

I agree to notify Mont Alto Family Practice of any pre-auth. requirements of insurance program I have selected. _____
Signature

If your prescription plan has a preferred drug and your doctor agrees to the change, do we have your permission? yes no

Can we contact you at work regarding medical care? yes no Phone number (_____)_____

PLEASE GIVE ALL INSURANCE CARDS TO STAFF UPON YOUR ARRIVAL

(TO MAKE COPIES FOR OUR RECORDS)

RESPONSIBLE PARTY FOR MEDICAL BILLING: SPOUSE / PARENT / GUARDIAN / POA

Full name _____ Birthdate _____

_____
street city state zip

Home phone (_____)_____ Social Security #_____

Employer name _____ Job _____

_____
street city state zip

Name of nearest relative not living with you _____

Address _____

Relationship _____ Phone (_____)_____

CONTACT PERSON INFORMATION

How can we contact you to confirm an appointment?

Phone (_____)_____ E-mail_____ Other_____

Other person to contact_____ Phone (_____)_____

Relationship _____ Address _____

To whom else may we give medical information about you over the phone such as labs, x-rays, etc? e.g. spouse, parents, roommate

Name_____ Phone (_____)_____ Relationship _____

Name_____ Phone (_____)_____ Relationship _____

I authorize the submission of claims for services directly to my (or my dependent's) insurance carrier including the release of any necessary information needed to process those claims and payment of benefits directly to Mont Alto Family Practice. I agree to pay for all charges not covered by a third party payer.

Signature _____ Date_____