

Please Print

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_ SS# \_\_\_\_\_

( ) Single ( ) Married ( ) Widowed ( ) Divorced ( ) Separated ( ) Student

Patient's or Parent/Guardian

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone (W): \_\_\_\_\_

Employer Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Spouse or Parent/Guardian

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Emergency Contact (Other than Spouse)

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Billing Information & Responsible Party \_\_\_\_\_

Billing Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_

Primary Insurance Information

Address: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ Effective Date: \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Authorization to Release Information

I hereby authorize McDonagh Medical Center to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

I do hereby state that the above information is correct and understand that I am responsible for paying my own account at time of service. Filing of insurance claims shall be my own responsibility.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PAYMENT REQUIRED AT TIME OF SERVICE - We accept Mastercard, Visa, Discover, American Express, Cash, or Check.

Referred by \_\_\_\_\_