McDonagh Medical Center **Welcome to our office** **Date**_____

Please Print

Patient Name: _____ Birthdate: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
Email address: _____
( ) 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 Number: _____

Emergency Contact (Other than Spouse)
Name: _____ Relationship: _____
Address: _____ Phone: _____

Billing Information & Responsible Party
Billing Name: _____ Relationship: _____
Address: _____ City, State, Zip: _____
Phone Number: _____

Primary Insurance Information
Address: _____
Phone Number: _____ Effective Date: _____
Group#: _____ ID #: _____
Policy Holder Name: _____ Relationship: _____
Secondary Insurance: _____ Policy Holder 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, check or cash.