WELCOME TO OUR OFFICE

PATIENT INFORMATION

Name (Last)_____ (First, Middle) _____

Date of Birth _____ Gender M or F

Address_____

City_____

State_____ Zip Code_____

Home Phone_____ Work_____

Cell Phone _____ E-mail _____@_____

Social Security Number_____

Allergies to Medication_____

PARENT SPOUSE LEGAL GUARDIAN (Circle one, if under the age of 18)

Name (Last)_____ (First, Middle) _____

Home Phone_____ Work_____

Cell Phone _____

IN CASE OF EMERGENCY, NOTIFY

Name_____Phone_____

Relationship to Patient_____

I authorize my physician to release to my insurance company or any third party any information, including diagnosis and records of such treatment as necessary to determine my eligibility for any procedure, my liability for payment, and to obtain reimbursement**. I also authorize and request my insurance companies to pay directly to my physician the amount due in my pending claim for medical care. I understand that I am financially responsible for all charges regardless of the insurance status and am aware that all outstanding balances will be subject to finance charges**. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician. It is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible, co-payment or other balances not paid for by your insurance.

SIGNATURE_____DATE_____

Do you have a living will? YES NO

Please let the staff know if you would like information regarding a living will.

Christian Family Care, Inc.
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