Floyd Memorial Medical Group

PATIENT INFORMATION

Last Name: _____ Maiden Name_____First Name: _____Middle: _____

Address: _____ City: _____ State: _____ Zip: _____ County: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Email Address: _____

☐Male ☐Female DOB: _____/_____/_____ State of Birth:_____ SS#: _____-_____-_____

Primary Care Physician: _____ Preferred Pharmacy/Location: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Other

Race: _____ Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Other/Undetermined

Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____Relationship: _____

Phone: ( ) _____ Type of phone: ☐Home ☐Work ☐Cell

Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____

Spouse's DOB: _____/_____/_____ Social Security Number: _____-_____-_____

Spouse's Employer: _____ Phone: ( ) _____

How did you hear about us? _____ Your Email address:_____

How would you like us to contact you? ☐Letter ☐Phone Call ☐Email

•••••••••••••••••••• RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT INFORMATION) ••••••••••••••••••••

Full Name: _____ ☐Male ☐Female

DOB:_____/_____/_____ SS#_____-_____-_____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Employer: _____

•• INSURANCE INFORMATION ••

Primary Insurance: _____ Policy Holder: _____

Date of Birth: _____/_____/_____ Relationship: _____

Insurance ID Number: _____Group Number: _____

Secondary Insurance: _____ Policy Holder: _____

Date of Birth: _____/_____/_____ Relationship: _____

Insurance ID Number: _____Group Number: _____

I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release medical information to my insurance company to secure payment of benefits. I also authorize the use of this signature on all insurance submissions and as authorization for payments to be sent to Floyd Memorial Hospital and Health Services. This signature authorizes release of medical records to any physicians or health care facility when referred of requested by them for continuity of care. I voluntarily consent to medical care including the routing of diagnostic testing, surgical procedures and additional medical treatment.

Responsible Party Signature: _____Relationship: _____Date: _____