Middletown Valley Family Medicine

PATIENT INFORMATION			
Patient's last name:	First:	Middle:	Marital status ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed

Date Of Birth:	Age:	Sex: ❑ M ❑ F	Home Phone Number:	Cell Phone Number:

Email Address:	
Street address:	Social Security:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone:
Race ❑American Indian/Alaskan Native ❑Multiracial ❑Black/African American ❑White/Caucasian ❑Asian ❑Refused /Undetermined ❑Native Hawaiian or other Pacific Islander	Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Refused or Undetermined	Primary Language ❑ English ❑ Spanish ❑ American Sign Language ❑ Other

INSURANCE INFORMATION			
Person responsible for bill:	Birth date:	Address (if different):	Home phone:
Is this person a patient here?	❑ Yes	❑ No	
Occupation:	Employer:	Employer address:	Employer phone:

Is this patient covered by insurance? ❑ Yes ❑ No		
Name of Primary Insurance:		
Subscriber's name:	Subscriber's Social Security:	Birth Date:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Subscriber's S.S:	Birth Date:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Home phone:	Work phone:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any charges not paid by my insurance. I agree to assign payments from my insurance company directly to Middletown Valley Family Medicine. I authorize Middletown Valley Family Medicine to provide my insurers with any information they may request. I agree to the financial policy of Middletown Valley Family Medicine and understand that I will be charged a monthly rebilling fee until my account is paid in full. I also agree that in the event that my account must be turned over to an agency for collection, I will be responsible for collection fees and any other associated costs. A photocopy of this assignment is considered to be as valid as the original.

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I AM THE PATIENT OR DULY AUTHORIZED TO ACT ON BEHALF OF THE PATIENT. I AGREE TO THE TERMS STATED ABOVE.

Patient's Signature: ____ Date: ____

Signature of Patient's Representative_________________________________ Relationship to Patient:______________________________