I. PATIENT INFORMATION

Patient Name: ____

Last *First* *Middle Initial*

Address: ____

Street *City* *State* *Zip*

Phone: ____

Preferred ☐ *Home* ☐ *Cell* ☐ *Office* ☐ *OK to Leave Voice Mail?* ***Secondary*** ☐ *Home* ☐ *Cell* ☐ *Office* ☐ *OK to Leave Voice Mail?*

Email: ____

Email Address **Please inform staff if you would like to receive an enrollment token for NextMD**

Date of Birth:_______________ Social Security No: __________________ Driver's License No: _______________

Occupation: _______________ Employer:_________________ Employer's Address: ______________________

Preferred Pharmacy: ________________ Address: ________________________Phone: ____________________

II. RESPONSIBLE PARTY (Please complete if different than Patient Information above)

Name: ____

Last *First* *Middle Initial*

Address: ____

Street *City* *State* *Zip*

Phone: ____

Preferred ☐ *Home* ☐ *Cell* ☐ *Office* ☐ *OK to Leave Voice Mail?* ***Secondary*** ☐ *Home* ☐ *Cell* ☐ *Office* ☐ *OK to Leave Voice Mail?*

Date of Birth:_______________ Social Security No: __________________ Driver's License No: _______________

Occupation: _______________ Employer:_________________ Employer's Address: ______________________

III. PRIMARY INSURANCE INFORMATION

Insurance Company: ________________ Identification No: __________________ Group No:________________

Subscriber's Name:________________________ Subscriber's Address:___________________________________

Subscriber's Date of Birth:___________________ Subscriber's Relationship to Patient: Self Child Spouse Other

Subscriber's Gender: ◯ Male ◯ Female Subscriber's Phone Number: _____________________________

IV. SECONDARY INSURANCE INFORMATION

Insurance Company: ________________ Identification No: __________________ Group No: ________________

Subscriber's Name: ________________________ Subscriber's Address: ____________________________________

Subscriber's Date of Birth: __________________ Subscriber's Relationship to Patient: ☐Self ☐Child ☐Spouse ☐Other

Subscriber's Gender: ◯Male ◯Female Subscriber's Phone Number: ______________________________

V. EMERGENCY CONTACT INFORMATION

Name of Person to Contact: ________________________ Relationship to Patient ____________________________

Preferred Phone Number _________________ ☐Home ☐Cell ☐Office ☐OK to Leave Message?

Secondary Phone Number _________________ ☐Home ☐Cell ☐Office ☐OK to Leave Message?

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payments for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot rendered services on the assumption that our charges will be paid by the insurance company. Insurance is an agreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.

Patient Signature: ____ Date: ____________________