Myrtle Ridge Family Medicine

THANK YOU FOR CHOOSING OUR OFFICE. IN ORDER TO SERVE YOU PROPERLY WE WILL NEED THE FOLLOWING INFORMATION. ALL INFORMATION WILL BE STRICTLY CONFIDENTIAL. (PLEASE PRINT)

PATIENT INFORMATION

DATE ________________

PATIENT NAME **DATE OF BIRTH** **M/F** **SOCIAL SECURITY #**

PATIENT ADDRESS **CITY** **STATE** **ZIP** **HOME PHONE (PATIENT)**

SPOUSE (or PARENT, IF CHILD) **ADDRESS** **CELL PHONE (PATIENT)**

EMPLOYER **ADDRESS** **WORK PHONE**

EMERGENCY CONTACT

NAME **RELATIONSHIP** **PHONE**

INSURANCE INFORMATION

DO YOU HAVE HEALTH INSURANCE? Y / N **DO YOU INTEND TO PAY with CASH ___CREDIT CARD ____DEBIT CARD_____**
(Sorry. We do not accept checks.)

INSURANCE COMPANY **GROUP POLICY #** **INSURED'S ID #**

INSURANCE COMPANY ADDRESS **PHONE #**

POLICY HOLDER'S NAME **DOB** **SOC SEC #** **INSURED's RELATIONSHIP TO PATIENT**

SECONDARY INSURANCE COMPANY **GROUP POLICY #** **INSURED'S ID #**

SECONDARY INSURANCE COMPANY ADDRESS **PHONE #**

POLICY HOLDER'S NAME **DOB** **SOC SEC #** **INSURED's RELATIONSHIP TO PATIENT**

HOW DID YOU HEAR ABOUT OUR OFFICE? **DO YOU HAVE A LIVING WILL?** **WOULD YOU LIKE ONE?**