Churchland Family Medicine, P.C.

Patient Name____ **Male**______ **Female**_____

Street Address____

City___________________________ **State**_____________ **Zip Code**_________________

Date of Birth___________________ **Social Security Number** _______________________

Home Phone _____________ **Work Phone**_______________ **Cell Phone**______________

E-mail Address____

Patient Employer ____

Employer Address ____

Contact in case of emergency ____________________________**Relationship** _____________

Phone number for emergency contact ____

Insurance Information:

Primary Insurance ____

Policy Number________________________________ **Group Number**__________________

Subscriber's name & address if different from above;_________________________________

Subscriber's Date of Birth ________________**Patient Relationship to Subscriber** _________

Secondary Insurance ____

Policy Number ________________________________ **Group Number**___________________

Subscriber's name & address if different from above; ________________________________

Subscriber's Date of Birth _________________**Patient Relationship to Subscriber**________

Responsible Party Information (If other than patient):

Name___________________________**Address**____

Home Phone _______________ **Cell Phone**______________ **Work Phone**________________

ASSIGNMENT AND RELEASE: I hereby give authorization for my insurance benefits to be paid directly to Churchland Family Medicine, P.C. I understand that I am financially responsible for all charges not paid for by insurance. I also authorize the release of any medical information needed to process insurance claims. In the event of default, I agree to pay the cost of all collections and reasonable legal fees.

Signed____ **Date**____________________________________