PATIENTS FIRST MEDICAL CLINIC, LLC

PATIENTS NAME: LAST_____FIRST_____MIDDLE_____

Sex: _____Race_____ _Ethnicity_____ Preferred Language_____ Marital Status: _____

DOB:_____ Social Security # _____

Mailing address:_____

ZIP_____City_____State_____

Physical address (if different from mailing)_____

Telephone Number (home)_____(cell)_____(work)_____

E-mail address: _____Preferred Contact Method: Phone Mail E-mail

Parent's Name (if patient is a child)_____Parent's SSN:_____

Employer:_____ **EMPLOYEE TYPE: PLEASE CIRCLE ONE**

Address:_____ Retired Fulltime Part time Unemployed

City, State, Zip_____ **Student Type:**

Phone #_____ Fulltime Part time

PRIMARY INSURANCE:_____

Policy ID #_____Group #_____

Subscriber Name _____Sex ____Martial Status _____DOB_____

Subscriber SS#_____Relationship to patient_____

Subscriber Employer & Address_____

SECONDARY INSURANCE:_____

Policy ID #_____Group #_____

Subscriber Name _____Sex ____Martial Status _____DOB_____

Subscriber SS#_____ Relationship to patient_____

Subscriber Employer & Address_____

EMERGENCY CONTACT:_____Phone_____Relationship_____

How did you learn about our clnic:_____

Consent to Treatment
By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor by signing I give consent for examination, tests, and/or procedures for the above named minor patient. I assume full responsibility for the cost of these tests and agree to pay at the time of the service. I agree that I am responsible for any costs which are not covered by insurance.
I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to the provider(s). I understand that I may revoke this consent at any time in writing to this office. I further understand that I am responsible for payment for all products and services rendered to me or any patient for which I am the guarantor of payment. All unpaid balances forwarded to collections will have an additional fee of 30 percent of the total bill added and is the patient's responsibility. I have read and understand the above statements.
X ***(print name)*** **Date:**
X ***(signature***