CREEKMORE CLINIC

NEW PATIENT INFORMATION

Date:________________

Name ____ S M W D Male / Female
First Middle Last
Date of Birth______________________ Age_________
Drug Allergies____
Social Security #____________________Drivers License ____________________
Mailing Address____
City, State, Zip____
Phone#_______________ Work#_______________Cell#_________________
Occupation/Employer____
Emergency Contact: Name___________________ Number_________________
EMAIL ADDRESS ____

PARENT/GUARDIAN INFORMATION of a child younger than age 18

Name___________________________________ Relationship_______________
Date of Birth________________Social Security #________________________
Mailing Address____
City, State, Zip____

PATIENT INSURANCE INFORMATION: *Will need copies of card(s)*

1. Primary Subscribers Name_____________________________DOB_______
Insurance Company____
ID#_________________Group#______________Effective Date____________

2. Secondary Subscribers Name___________________________DOB_______
Insurance Company____
ID#_________________Group#______________Effective Date____________

Medicare #______________________Medicaid#_________________________

PAYMENT REQUESTED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Creekmore Clinic for services rendered by Creekmore Clinic Partnership, by their medical staff in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Creekmore Clinic Partnership to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE * MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original

Patient X____Date:________________

Parent/Guardian X____Date:________________