

PATIENT NAME: _____
(First) (Middle Init.) (Last) (Suffix)

ADDRESS: _____
(Number & Street, Apt#) (City) (State) (Zip)

DATE OF BIRTH _____ SEX: M F SSN: _____

TELEPHONE: (Home) _____ (Cell) _____ (Work) _____

PRIORITY OF NOTIFICATION: 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____
(H=home phone W=work phone C=cell phone O=other E=email)

MARITAL STATUS: _____ EMAIL ADDRESS: _____

EMERGENCY CONTACT NAME: _____ PHONE#: _____

RELATIONSHIP TO EMERGENCY CONTACT: _____

PHARMACY: _____ PHONE#: _____

PRIMARY INSURANCE

CARRIER: _____

SUBSCRIBER'S NAME: _____ RELATION TO PATIENT: _____

SUBSCRIBER'S SS# _____ SUBSCRIBER'S DATE OF BIRTH: _____

POLICY#: _____ GROUP# _____

SECONDARY INSURANCE

CARRIER: _____

SUBSCRIBER'S NAME: _____ RELATION TO PATIENT: _____

SUBSCRIBER'S SS# _____ SUBSCRIBER'S DATE OF BIRTH: _____

POLICY#: _____ GROUP# _____

CANCELLATION POLICY: I have read and understand the cancellation policy of Doylestown Family Medicine as it applies to myself and my family (if applicable).

Signed _____ Date _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signed _____ Date _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DOYLESTOWN FAMILY MEDICINE.

Signed _____ Date _____

MEDICARE BENEFICIARIES ONLY: _____ MEDICARE IS MY ONLY PRIMARY INSURANCE CARRIER
_____ MEDICARE IS MY SECONDARY INSURANCE CARRIER

Signed _____ Date _____