LET'S GET TO KNOW EACH OTHER

Name: _____ Date of Birth: _____ SEX: ☐ Male ☐ Female

Address:_____ City/State/Zip: _____

Home Phone #: _____ Cell #: _____

Email Address (we will email you): _____

Social Security #: _____ Driver's License #: _____

Employer Name: _____ Work Phone #: _____

Insurance Information

Primary Insurance Carrier: _____ Insurance Carrier Phone #:_____

Insurance ID#: _____ Group #: _____

Name of insured:_____ Relationship to Patient: _____

Date of Birth: : _____

Secondary Insurance Carrier: _____ Insurance Carrier Phone #:_____

Insurance ID#: _____ Group #: _____

Name of insured:_____ Relationship to Patient: _____

In Case of Emergency, whom should we notify?

Name: _____ Phone: _____

I hereby consent to and authorize the administration of diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of MD Health Clinics. I understand that I am financially responsible for all medical bills. I further understand that MD Health Clinics Providers may be a non- participating (out of network) and as such not contracted with your insurance carrier. I understand that by signing this patient information sheet I authorize MD Health Clinics and his collections agency to check my credit with any credit reporting agency, verify my employment and insurance information. I certify this information is correct and true.

Patient Signature: _____ Date: _____

Referred by:_____

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