Patient Information

Patient Name_____
First Middle Initial Last

Street Address_____

City_____ **State**_____ **Zip**_____

Birth Date_____ **Age**_____ **Marital Status** M □ W □ S □ D □

SS No._____ **Male □ Female □**

****Home Phone**_____ **Referring Dr**_____

****Cell Phone**_____ **Referring Dr Phone**_____

Email Address_____

Employed Yes □ Employer_____ **Work Phone**_____
Employed No □

Emergency Contact Name_____ **Phone No.**_____

Responsible Party Same □ Different □ Name_____
If Different:
Responsible Party SS No_____
Responsible Address Same □ Different □
If Different:
Responsible Street Address_____

City_____ **State**_____ **Zip**_____

Insurance Information

Primary Insurance Yes □ No □
If Yes: *BCBS □ Medicare □ Medicaid □ Other □* Ins Name_____
Is the Patient the Policy Holder Yes □ No □
If No: Policy Holder Name_____ **Birth Date**_____
Relationship to Policy Holder *Self □ Spouse □ Child □ Other □*
Secondary Insurance Yes □ No □
If Yes: *BCBS □ Medicare □ Medicaid □ Other □* Ins Name_____
Is the Patient the Policy Holder Yes □ No □
If No: Policy Holder Name_____ **Birth Date**_____
Relationship to Policy Holder *Self □ Spouse □ Child □ Other □*

ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE. **I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any service rendered. I authorize direct payment of medical and surgical benefits to Moulton Group PC. I authorize release of information necessary to process any insurance claims submitted by Moulton Group PC. If a biopsy or lab work is performed on me, I am responsible for calling the doctor in a week for the results.**

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Patient or Responsible Party Signature *Date*