PromptMD

PLEASE CLEARLY PRINT ALL PATIENT INFORMATION **Today's date:**_____

Last Name:_____ **First Name:**_____ **MI:**_____

Gender: Male or Female **Date of Birth:**_____ **Age:**_____ **SS#:**_____

Home Address:_____ **Unit or Apt#** _____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone #:_____-_____-_____ **Ok to leave voicemail on home phone:** YES or NO

Cell Phone #:_____-_____-_____ **Ok to leave voicemail on cell phone:** YES or NO

Confidential Email Address:_____ **Primary Care Physician:**_____

Pharmacy Used:_____ **Pharmacy Location:**_____

Emergency Contact:_____ **Relationship:**_____ **Phone:**_____

Race (PLEASE CIRCLE): Am Indian or Alaska Pacific, Asian, Black African Am, White, or Other **Ethnicity:** Hispanic or Latino or Other

Reason for visit:_____

INSURANCE INFORMATION

Name of Primary Insurance: _____ **Insurance ID:**_____ **Group:**_____

Policy Holder's Name:_____ **Relationship to Patient:**_____

Policy Holder's DOB:_____ **Secondary Insurance:**_____

GUARANTOR SECTION-COMPLETE IF PATIENT IS UNDER THE AGE OF 18

Guarantor Name (person financially responsible):_____ **Relationship:**_____

Address (if different from patient):_____ **Unit or APT#:**_____

City:_____ **State:**_____ **Zip Code:**_____

_____

FINANCIAL POLICY (We accept credit or debit cards, cash. Personal checks are not accepted.)

I acknowledge full financial responsibility to any services received and I understand that the payment of charges incurred is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign endurance benefits to this office. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees and/or Attorney's fees and all court costs, if any. Please indicate method of payment for today's visit: ☐ *Cash* ☐ *Credit Card* ☐ *Medicare* ☐ *Insurance*

*In order for us to service your account or to collect any amounts owed to us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which may result in additional charges from your phone carrier. We may also contact you by text/email. By initialing, I acknowledge that I have read this disclosure and agree that you may contact me as described above. X*_____

I, the undersigned, consent to the care and treatment by the attending Physician, his/associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

I have reviewed the Notice of Privacy as provided at registration and understand that I may request a copy of the policy at any time.

Signature: _____ **Date:**_____