Masonboro Family Medicine

Please complete all sections:

Patient full Name: _____ Date of Birth: _____
Birth Sex: Male/Female Identify as: male/female/non binary/refuse to answer
Marital status: ____Primary Language: _____Race: _____ Refused Ethnicity: Hispanic/ Non-Hispanic
Email: _____

Patient Address:
_____
_____
_____
Primary Contact Phone Number: _____
Secondary Contact Phone Number: _____

Responsible Party if other than Patient Mailing Address
Name: _____
Address: _____
_____
_____
Contact Phone Number: _____

Employer Name: _____ Full time/ Part time/ Retired/ Student
Employer Phone Number: _____

In case of emergency call: (1) _____ Relationship_____ Phone Number: _____
(2) _____ Relationship_____ Phone Number: _____

Primary Insurance Information

Name of Insurance Company: _____
Policy Holder/Subscriber Name: _____
Policy Holder Date of Birth: _____
Relationship to Patient: _____

Secondary Insurance Information

Name of Insurance Company: _____
Policy Holder/Subscriber Name: _____
Policy Holder Date of Birth: _____
Relationship to Patient: _____

ASSIGNMENT AND RELEASE OF INFORMATION

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliance resolutions. I authorize payment directly to MASONBORO FAMILY MEDICINE, P.C. for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. I understand that while MASONBORO FAMILY MEDICINE, P.C. will make every effort to notify me that a service may not be covered by my insurance, I agree that I will be financially responsible for any services considered not covered by my insurance. A photocopy of this authorization shall be considered as effective and as valid as the original.

May we leave normal lab results on your answering machine/ voice mail/ cell phone? YES / NO
Besides yourself, who may we discuss your medical information (including lab & x-ray results) billing information

Name: _____ Relationship _____ Phone Number: _____
Name: _____ Relationship _____ Phone Number: _____

MFM REQUIRES A COPY OF YOUR MOST RECENT INSURANCE CARD TO FILE YOUR INSURANCE. WITHOUT A CURRENT INSURANCE CARD WE WILL BE UNABLE TO FILE YOUR INSURANCE AND YOU WILL BE RESPONSIBLE FOR ALL CHARGES AT THE TIME OF SERVICE. COPAYS ARE DUE AT TIME OF SERVICE.

Patient or Responsible Party Signature: _____ Date_____
Printed Name: _____Relationship to Patient _____