Community Medical PA

520 W. Main St Marshville NC 28103

704-624-3388

Last First MI

Name: _____

Social Security Number: _____-_____-_____ Date of Birth: _____

Pharmacy: _____ Phone #: _____

Home Address: _____ APT #: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____ (Same as Above)

City: _____ State: _____ Zip: _____

Phone Number: Home _(_____)_____ Cell _(____)_____

Employer _____ Work #_____

Email: _____

Insurance: Primary-_____ ID #-_____

Secondary-_____ ID #-_____

Marital Status: | Married | Single | Divorced | Widowed |

Race: | African American | White | Hispanic | Other |

Language: | English | Spanish | Other |

Next Of Kin: _____ Phone: _____

Are we able to speak with them regarding your healthcare? | Yes | No |

Assignment of Benefits authorization for treatment. **1)** I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance company for payment**. 2)** I further authorize that payment of benefits to be made to the provider on my behalf. I understand I am financially responsible for all charges not covered by my insurance. **3)** I hereby authorize COMMUNITY MEDICAL PA to release any information acquired in course of my examination or treatment. **4)**I hereby authorize any physician, hospital, or medical facility to provide **all** information on my medical history and treatment **to Community Medical PA.**

Patient Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____