Community Medical

520 West Main Street, Marshville, NC 28103

Name: _____

Social Security Number: _____ Birth date: _____

Pharmacy: _____

Home Address: _____

City _____ State _____ Zip _____

Mailing Address: Same as above Other: _____

_____

Email: _____

Phone: Home _____

Cell _____

Work _____

Employer: _____

Address: _____

_____

Marital Status: Married Single Divorced Widowed

Race: _____ Ethnicity: African American Caucasian/ Non-Hispanic Hispanic

Language: English Spanish Other: _____

Next of Kin: _____ Phone _____

Address: _____ Relation to patient:

_____

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

Signature: _____ Date: _____

Printed Name: _____ Relation to patient: _____

Responsible Party for Minors under 18 years of age:

Name: _____

Social Security Number: _____

Birth date: _____ Age _____

Home Address: _____

City _____ State _____ Zip _____

Mailing Address: Same as above Other: _____

_____

Signature _____