MALTA MEDICAL CARE

Patient's Name (first, middle & last): _____

Permanent Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Email _____

Date of Birth: _____ Sex: M ___ F ___ Patient's Social Security No. _____

Marital Status: M___ S___ D___ W___

My Employer's Name: _____

Address: _____
Street City State Zip

My Spouse's Name: _____

Address: _____

Work #: _____ Date of Birth: _____

In case of emergency, contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Person responsible for payment: _____ Phone (if different from above): _____

Relationship to patient: _____

Address (If different from above): _____
Street City State Zip

I hereby authorize and direct payment to Malta Medical Care for the surgical and/or medical benefits, if any, otherwise payable to me under terms of my insurance.

I hereby authorize Malta Medical Care to release any information acquired in the course of my examination or treatment, I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to Malta Medical Care.

I hereby authorize photocopies of this to be valid as the original.

Date: _____ Parent or Patient's Signature: _____