

Patient Information	Patient Information			
	Last Name:		First Name:	M.I.:
	Mailing Address:			Apt #
	City/State/Zip:			
	Home Phone:		Cell Phone:	Work Phone:
	Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) <input checked="" type="radio"/> Voice <input checked="" type="radio"/> Text			If Voice, Please Select Preferred Number: <input checked="" type="radio"/> Home <input checked="" type="radio"/> Cell <input checked="" type="radio"/> Work
	Family Physician or Pediatrician:		Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Marital Status:		Social Security #:	
	Employer Name:		Emergency Contact Name:	
	Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party	Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor			
	Last Name:		First Name:	
	Date of Birth:	Social Security #:		Phone:
	Address of Person Responsible:			
	City/State/Zip:		Relationship to Patient:	
	Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)			
	Email Address:		Can we leave a message regarding your medical care & test results? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Race (please select): <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline		Ethnicity (please select one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline	
	Preferred Language (please select one): <input type="checkbox"/> English <input type="checkbox"/> Bosnian <input type="checkbox"/> Indian (including Hindi & Tamil) <input type="checkbox"/> Sign Language <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Other			
	Preferred Pharmacy Name & Location:			

Insurance Information	Primary Medical Insurance		Secondary Medical Insurance	
	Ins. Co. Name		Ins. Co. Name	
	Policy Holder Name:		Policy Holder Name:	
	Policy Holder's Date of Birth:		Policy Holder's Date of Birth:	
	Policy Holder's Social Security #:		Policy Holder's Social Security #:	
	Patient Relationship to Policy Holder:		Patient Relationship to Policy Holder:	

I certify that I have read and agree to Macley Family Practice and Walk-in Clinic (MFPWC) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to MFPWC all money to which I am entitled for medical expenses related to the services performed from time to time by MFPWC, but not to exceed my indebtedness to MFPWC. I authorize MFPWC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A \$20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from MFPWC by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to MFPWC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Macley Family Practice and Walk-in Clinic's Privacy Notice. (Initials)

Signature of Responsible Party: X _____ Date: _____

Printed Name of Responsible Party: X _____ Date: _____