Patient Information

Name_____Date of Birth_____
Street Address_____
City_____State_____ Zip Code _____
Cell Phone (_____) _____ Home Phone (____) _____
Email Address_____
Preferred Contact Method: ( ) Cell phone ( ) Home phone ( ) Portal
Gender_____ Marital Status_____
Employer _____
Employer Address_____
Employer Phone (_____) _____Employer Fax (_____) _____

Responsible Party (if the patient is a minor)

Name_____ Relationship_____
Street Address_____
City_____ State_____ Zip Code _____
Cell Phone (_____) _____ Home Phone (____) _____

Emergency Contact

Name_____ Cell Phone (____) _____
Home Phone (_____) _____Work Phone (____) _____

Primary Insurance

Name of Insurance Company_____
Name of Policy Holder_____ Date of Birth_____
Relationship to Patient_____
Group Number_____ Policy ID Number_____

Secondary Insurance

Name of Insurance Company_____
Name of Policy Holder_____ Date of Birth_____
Relationship to Patient_____
Group Number_____ Policy ID Number_____

Authorization/Consent for Treatment/Assignment of Benefits

I hereby consent to treatment (for myself or any minors under my care) by Fox Ridge Medical Associates, LLC. I authorized my insurance carrier to issue payments directly to Fox Ridge Medical Associates, LLC. I authorize the release of any medical information needed by my insurance carrier. I understand that this authorization will apply to all medical services rendered, until such authorization is revoked by me in writing.

Signature of patient (or responsible party) _____

Date_____