

CENTOC MEDICAL GROUP, INC.

PATIENT INFORMATION

PATIENTS NAME _____ DOB _____ SS# _____ AGE _____ M or F

NICKNAME _____ Name(s) of any member of your family treated in this office _____

RESPONSIBLE PARTY _____ RELATIONSHIP _____

FAMILY INFORMATION

MOTHER _____ BIRTHDATE _____ MARITAL STATUS _____

SS# _____ HOME PHONE _____ DRIVER'S LIC# _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ BUS. PHONE _____ OCCUPATION _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

FATHER _____ BIRTHDATE _____ MARITAL STATUS _____

SS# _____ HOME PHONE _____ DRIVER'S LIC# _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ BUS. PHONE _____ OCCUPATION _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE CO. (1) _____ INSURANCE CO. (2) _____

ADDRESS _____ ADDRESS _____

_____ ZIP _____ _____ ZIP _____

PHONE# _____ GR# _____ PHONE# _____ GR# _____

MEMBER CERTIFICATE NO. _____ MEMBER CERTIFICATE NO. _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S NAME _____

Who referred you to our office? _____ Child's Physician (PCP) _____

PCP's address _____ Phone _____

Friend or relative whom we can contact in an emergency _____

(Include address and phone #) _____

INSURANCE ELIGIBILITY GUARANTEE: I understand that if the above health insurance information provided by myself is not true or if I am not eligible under the terms of the Medical Subscriber Agreement, I am responsible for any and all charges for service rendered. Also if I am not eligible for health insurance coverage, I agree to pay in full for all services rendered within thirty (30) days of receiving a bill from the provider office.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS: I hereby authorize the release of any medical information necessary to process insurance claims and authorize payment of benefits to the attending physician.

SIGNATURE OF RESPONSIBLE PERSON

RELATIONSHIP

DATE