

MEDICAL CARE LLC



"Medical Care with a Heart"

Acct: _____

MEDICAL CARE PLLC

www.medicalcarellc.com

2012

PLEASE USE BLACK INK AND PRESS FIRMLY

Thank you for taking time to fill out the following information. It is necessary for Medical Care LLC to update each patient's chart annually in order to serve the patient's medical needs. Please make sure each question is answered correctly. Incorrect or missing information can result in insurance filing problems and/or failure to contact the patient with important information.

PATIENT INFORMATION

First _____ Middle: _____ Last: _____

Street (include apt or lot number): _____

City: _____ State: _____ ZIP: _____

Mailing Address if different: _____

Birth Date: _____ Male: _____ Female: _____ Marital Status: _____

Hispanic/Latino yes _____ no _____

Race: White _____ Black/African American _____ Asian _____ American Indian/Alaska _____ Other _____

Primary Phone: _____ / _____ Secondary Phone: _____ / _____

Emergency Phone: _____ / _____ Name/Relationship: _____

Patient's Social Security Number: _____ Employer: _____

Payment Information: CASH PRIVATE INSURANCE MEDICARE TNCARE

Please have Insurance card or Driver's License available.

RESPONSIBLE PARTY (REQUIRED IF PATIENT IS UNDER 18)

NAME: First: _____ MI: _____ Last: _____

Street: _____ City: _____ State: _____ ZIP: _____

Date of Birth: _____ Social Security #: _____

Relationship to patient: _____ If a student which school do they attend: _____

INSURANCE CARD INFORMATION (IF PATIENT'S NAME IS DIFFERENT THAN CARD)

Name of Cardholder First: _____ MI: _____ Last: _____

Cardholder's Date of Birth: _____ Social Security #: _____

Relationship to patient: _____