

Medical Care



"Medical Care with a Heart"

Medical Care PLLC

www.medicalcarepllc.com

2015

PLEASE USE BLACK INK AND PRESS FIRMLY

Thank you for taking time to fill out the following information. It is necessary for Medical Care PLLC 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: _____

Date of Birth: _____ Street (include Apt/Lot #): _____

City: _____ State: _____ ZIP: _____

Mailing Address (if different): _____

Phone Home :(_____) _____ Daytime/Work :(_____) _____ Mobile :(_____) _____

Patient's Social Security Number: _____ Marital Status: _____

Emergency Phone :(_____) _____ Name/Relationship: _____

E-Mail: _____ Decline _____ Do not have _____

Employer: _____

Male: _____ Female: _____ Hispanic/Latino Yes: _____ No: _____

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

Payment Information: CASH PRIVATE INSURANCE MEDICARE TNCARE

Please have insurance card and Driver's License available.

RESPONSIBLE PARTY (REQUIRED IF PATIENT IS UNDER 18)

First: _____ Middle: _____ Last: _____

Street (include Apt/Lot #): _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ Social Security Number: _____

Relationship to patient: _____ If a student, name of school: _____

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

First: _____ Middle: _____ Last: _____

Date of Birth: _____ Social Security Number: _____

Relationship to patient: _____