MEDICAL ASSOCIATES OF MIDDLETOWN

Patient's Legal Name:____Birth Date_________________________

SSN____ Sex: M F Marital Status: S M W D Sep

Street Address____

City and State____Zip Code______________________

Home Phone #____ Cell #____

Family Doctor____

______I am retired ______I am unemployed ______I receive disability benefits

Employed by____

Employer Street Address____

City/State_______________________________Zip Code___________________Phone_________________________________

Spouse or Parent's (if patient is a minor) name____

Birth Date________________________________ SSN____

Daytime Phone #____

Spouse or Parent (if patient is a minor) employed by:____

Employer Street Address____

City and State____Zip Code________________________

Emergency Contact Person____

Telephone #____ Relationship to Patient________________________

Who referred you to our practice?____

By signing below, I request that payment of authorized Insurance Benefits be made on my behalf to Medical Associates of Middletown for any services furnished me by this physician. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services, as determined by the Medicare carrier.

Signature:____

Date:____