

Poolesville Family Practice

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***Certified, American Board of Family Medicine**

Name (First, Middle, Last): _____ Date of Birth: _____ Age: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient's Occupation: _____ Name of Employer: _____

Marital Status: _____ Gender: ()Male ()Female Social Security #*: _____
*Necessary to submit bill to Insurance

Name of Emergency Contact: _____ Phone #: _____

How Did You Hear About Us?: ()Friend/Family _____ ()Phonebook Ad ()Postcard () Other: _____

Billing Information:

Send Bill To (If different from patient):

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____ Employer: _____

I understand the standard policy of Poolesville Family Practice is payment at time of service. I understand that I am ultimately responsible for the bill, regardless of my insurance coverage. I agree to pay all of my charges promptly when billed for medical services rendered. I accept all charges for the patient named above.

Signature: _____

Insurance Information:

(Please fill out even if you have given us your insurance card)

Primary Health Insurance: _____ ID#: _____ Group#: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Subscriber's Soc. Sec.#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____ Employer: _____

I hereby authorize Poolesville Family Practice to apply for benefits on my behalf for covered medical services rendered. I request payment be made directly to Poolesville Family Practice. I certify that the information provided is correct and further authorize release of any necessary information, including medical information for any claim by Poolesville Family Practice to the above named billing agent.

Date: _____ Name: _____ Signature: _____