Salters Creek MEDICAL GROUP

PATIENT INFORMATION:

Today's Date: _____

Name: _____ , _____
Last Name First Name Middle Name

Soc Sec # _____ **M**ale **F**emale Date of Birth: _____ /_____ /_____ Age: _____

Mobile Phone#: ( ) _____ Home Phone: ( ) _____ *Same as Mobile*

Email address: _____ Work Phone: ( ) _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Circle Preferred method of communication: Email Home Phone Mail Mobile Phone Work Phone Does not matter

In an Emergency contact: Name: _____ Phone: ( ) _____

The Name of my Family Doctor (PCP): _____ Phone: ( ) _____

☑ Please provide your Insurance Information and Driver's License to the Receptionist.

☐ I want SCMG to bill my insurance. ☐ I Have Insurance but I DO NOT want SCMG to bill it. ☐ I do not have health insurance.

AUTHORIZATION, ASSIGNMENT, & RELEASE:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent now and in the future to third party payers and/or other health care practitioners. I have signed an additional Authorization to Disclose Protected Health Information agreement. I authorize and request my insurance company &/or attorney to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier and/or attorney may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the case of default on payment on my account, I agree to pay collection costs and reasonable attorney fees of 33.33% incurred in attempting to collect on this amount or any future outstanding account balances. I authorize SCMG to text, SMS, and VM me reminders about appointments &/or treatment related information. I authorize SCMG to Email me reminders about appointments &/or treatment related information.

X _____ _____
Signature of Patient or Parent if the patient is a minor Date

For Accident Patients only……

I WAS INVOLVED IN AN ACCIDENT: Type of Accident: Auto? Slip & Fall? Work Related? Other.

Date of Accident: _____ Time: _____ Location: _____
Streets and town

Did you go to the ER? Yes No Name of Hospital: _____

Name of your Attorney and/or Attorney's Firm: _____
Attorney's Address: _____