CareMore Medical Group

PATIENT INFORMATION

Name (Last, First, Middle)	MRN	SSN#	Birthdate	Language	Sex

Address	City, State, ZIP	Primary Care Provider	Secondary/Billing Address (if Applicable)

Home Phone	Day Phone	Email Address	Emergency Contact Name	City, State, ZIP

Martial Status	Student Status ❑ Full-Time ❑ Part-Time	Smoker (Y/N)	Veteran (Y/N)	Emergency Contact Phone	Contact Phone	Home Phone

Primary Employer	Secondary Employer (if Applicable)
Address	Address
City, State, ZIP	City, State, ZIP
Work Phone	Work Phone

RESPONSIBLE PARTY INFORMATION (if Different than above)

Name (Last, First, Middle)	SSN#	Birthdate	Language	Sex

Address	City, State, ZIP	Secondary/Billing Address (if Applicable)

Home Phone	Day Phone	Email Address	City, State, ZIP

Martial Status	Student Status ❑ Full-Time ❑ Part-Time	Smoker (Y/N)	Veteran (Y/N)	Primary Care Provider	Home Phone

Relationship to Patient	

PRIMARY INSURANCE

Name of Insurance Company	Policy#
Name of Insured	Group#
Address of Insurance Company	Copay Amount $
City, State, ZIP / Phone	Deductible $
Relationship to Patient	Effective Date / Expiration Date

CareMore MEDICAL GROUP

SECONDARY INSURANCE (if Applicable)			
Name of Insurance Company		Policy#	
Name of Insured		Group#	
Address of Insurance Company		Copay Amount $	
City, State, ZIP	Phone	Deductible $	
Relationship to Patient		Effective Date	Expiration Date

Authorization for release of medical information: I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and it's agents to determine benefits for service provided to me by CareMore. I understand that I am financially responsible to CareMore for charges not covered by this agreement. I authorize refund or overpaid insurance benefits where my coverage are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. Authorization to treat: I consent too examination, treatment, and procedures which may be performed during office visits including emergency treatment considered necessary by the physician.

Signature of Patient/Guardian

Date