



ACCOUNT # _____

First Name _____ M _____ Last Name _____

Address _____ Apt.# _____

City _____ State _____ Zip Code _____

SS# ____/____/____ Date of Birth ____/____/____ Age ____ Sex ____ Marital Status _____

Email Address _____ Phone # _____ Cell # _____

Emergency Contact _____ Phone # _____ Cell # _____

Primary Care Physician: _____ Phone # _____

Pharmacy _____ Location _____

New Government regulations require Medical Offices to ask the following questions -

Language _____ Race _____ Ethnicity _____ Refused _____

PATIENT EMPLOYER:

Occupation _____ Business # _____

Company Name & Address _____

MEDICAL INSURANCE INFORMATION:

Primary Insurance _____ Secondary Insurance _____ Selfpay _____

I, undersigned, give my authorization to treat and assign directly to Horizon Medical Group, P.C. all medical benefits, if any otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

SIGNATURE _____

DATE _____

January 2012