

Ottawa Medical Center, P.C.

PATIENT INFORMATION								
Patient Last Name		M.I.		Legal First Name		Home Phone		
Street Address				Apt.		Cell Phone		
City			State		Zip Code		Work Phone	Ext.
Sex <input type="checkbox"/> F <input type="checkbox"/> M	Social Security Number		Date of Birth		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Employer			Employer Address					
INSURANCE INFORMATION								
Primary Insurance Carrier				Secondary Insurance Carrier				
Subscriber ID/Policy #			Group #	Subscriber ID/Policy #			Group #	
<i>Complete the following if the Patient is not the Subscriber</i>				<i>Complete the following if the Patient is not the Subscriber</i>				
Subscriber Name				Subscriber Name				
Date of Birth		Social Security Number		Date of Birth		Social Security Number		
Relationship to Patient				Relationship to Patient				
PARENT INFORMATION <i>(If patient is under 18 or insurance is in parent's name, please complete this section)</i>								
MOTHER OR GUARDIAN				FATHER OR GUARDIAN				
Name			Date of Birth	Name			Date of Birth	
Employer			Employer Phone	Employer			Employer Phone	
Employer Address				Employer Address				
EMERGENCY CONTACT								
Name			Relationship		Phone	Address		
Name			Relationship		Phone	Address		
AUTHORIZATION TO RELEASE MEDICAL INFORMATION								
<p>I understand that payment is required at the time of service, and should my claims be filed to my insurance company, any unpaid balance is my responsibility. When necessary, I further authorize release of my medical records to my insurance company. I understand that the Ottawa Medical Center physicians may recommend and perform services not covered by my insurance carrier. In consideration of services rendered and materials furnished to me or my child I agree to pay and/or authorize payment of medical benefits to the Ottawa Medical Center, P.C.</p> <p style="text-align: center;">I have read and agree to the above statements.</p> <p>Signed <input type="checkbox"/> _____ <input type="checkbox"/> _____ Patient / Parent / Guardian Date</p> <p style="text-align: center;">We need your help!</p> <p style="text-align: center;">In order to provide excellent service to you and your family, we depend on <u>you</u> for current and accurate information. Please inform us immediately if your insurance or contact information changes.</p>								
THANK YOU								