MOUNT PLEASANT
MEDICAL ASSOCIATES

We want to provide you with the very best health care possible. We realize your time is valuable, and our staff will try to attend to you as quickly as possible. Please fill out the biographical information for our computer file. Use you legal name, not a nickname or abbreviated name. If you prefer to be addressed by a nickname, please let the staff know. Thank you.

****

PLEASE PRINT Date: _____

Name: _____
Last *First* *M.I.*

Street Address: _____

P.O. Box:_____ Apt. No. _____

City: _____State: ____ Zip: _____

Home Phone: ( ) _____

Alternate Phone: ( ) _____

Social Security #: _____

Birth Date: _____/____/____ Race: _____

Spouse's Name: _____

Spouse's Birth date: _____

Spouse's Employer: _____

Employer Address: _____

_____

Employer Phone #: ( ) _____

Emergency Contact Person: _____

Phone: ( ) _____

Relationship to Patient: _____

****Alternate address: if you are a college student or have a secondary home:**

Alternate Address:_____

P.O. Box: _____ Apt. No. _____

City_____ State: ____ Zip: _____

Marital status: ____married ____single ____widowed ____divorced ____ other relationship

Employment status:___full time___part time___self ___not employed___retired___active duty

Employer: _____

Address: _____

_____

Work Phone: ( ) _____Ext: _____

Student Status: ___full time ___part time

Primary Insurance: _____

Name of subscriber: _____

Birth date of subscriber: ____/____/____ Sex: M / F

Social Security # of subscriber: _____

Relationship of subscriber to patient: _____

Subscriber Employer: _____

Employer address: _____

Secondary Insurance: _____

Name of subscriber: _____

Birth date of subscriber: ____/____/____ Sex: M / F

Social Security # of subscriber: _____

Relationship of subscriber to patient: _____

Subscriber Employer: _____

IF PATIENT IS A MINOR:

Father's Name: _____ Soc. Security #: _____ Birth date:___/___/___

* If Different from Above-Address: _____ City:_____State:___ Zip: _____

Home Phone: ( ) _____ Employer: _____ Work Phone: ( ) _____

Mother's Name: _____Soc. Security #: _____ Birth date: ___/___/___

* If Different from Above-Address: _____ City:_____State:___ Zip: _____

Home Phone: ( ) _____ Employer: _____ Work Phone: ( ) _____

MEDICARE & CHAMPUS AUTHORIZATION:

Patient Signature (required for billing)_____

Medicare number _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mount Pleasant Medical Associates for any services furnished to me by an employed physician or practitioner. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services.

COMMERCIAL & MEDIGAP AUTHORIZATION:

Patient Signature (required for billing) _____

Policy number _____

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