Chocowinity family care

REGISTRATION

PERSONAL INFORMATION

Name of Patient:_____
First Middle Initial Last

Name Preferred to be Called:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone #:_____ Cell #:_____

Employer/Employer Address:_____ Work Phone #:_____

Social Security #:_____ Date of Birth:_____

Race:_____ Sex:_____M _____F Marital Status _____Single _____Married _____Widowed ____ Separated ____Divorced

Do you have an Advanced Directive/Living Will: Yes _____ No _____

Next of Kin: Name:_____ Relationship:_____

Address:_____

Telephone #:_____ In Case of Emergency #:_____

RESPONSIBLE PARTY/GUARANTOR

Responsible Party/Guarantor:_____
First Middle Initial Last

Street Address:_____ Social Security #:_____ Date of Birth:_____

City:_____ State:_____ Zip:_____

Home Phone #:_____ Cell #:_____

Employer/Employer Address:_____ Work Phone #:_____

INSURANCE INFORMATION

Do you have Medical Insurance ___No ___Yes

Name of Primary Insurance Company:_____

ID #:_____ Group #:_____ Policy #:_____

Name of Secondary Company:_____

ID #:_____ Group #:_____ Policy #:_____

Medicare: ID #:_____ **Medicaid:** ID #:_____

ASSIGNMENT AND RELEASE

I hereby authorize the release of any medical information necessary to process this claim on behalf of myself/or dependents. I also authorize payment of medical benefits to Chocowinity Family Care for medical services rendered.

_____ _____
Signature **Date**

6265-14 MM
3/10/04 rev.
MW 97 sbg