EDINGER MEDICAL GROUP

Account Number:_____

Date:_____

PATIENT INFORMATION

Patient Last Name:_____ First Name: _____ MI: _____ Sex: ○M ○F

Name You Prefer: _____ SSN: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

(Please check preferred phone number for contact and messages)

Home Phone: ○_____ Cell Phone: ○_____ Work Phone: ○_____

Email Address: _____ Marital Status: ○Married ○Single ○Divorced ○Widowed ○Minor

Employer: _____ Occupation: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Employer: _____ Occupation: _____

INSURANCE INFORMATION

Do you have Medical Insurance? ○Yes ○No

Primary Insurance

Insurance Comp. Name: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Subscriber/ID #: _____

Group/Plan #: _____

Secondary

Insurance Comp. Name: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Subscriber/ID #: _____

Group/Plan #: _____

Emergency Notification In case of emergency, whom should we contact?

Name:_____ Relationship:_____ Phone:_____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Contact If we are unable to reach you for Urgent Medical Issues, whom should we contact?

Name:_____ Relationship:_____ Phone:_____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Assignment and Authorization

I hereby authorize Edinger Medical Group to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments for medical services rendered to my dependents or myself to Edinger Medical Group. I understand that I am responsible for any amount not covered by insurance. Initial: ____

Pharmacy History Authorization

I hereby authorize the physicians of Edinger Medical Group to review my medication history as prescribed by other physicians.
Initial: ____

Signature: _____ Date: _____