Carrollton Primary Care

Patient Information:

Name: _____ Date of Birth: _____ Gender: M F

Address: _____ City: _____ State____ Zip_____

Social Security #: _____ Marital status☐Married ☐Single☐Divorced☐Widow

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Preferred method of contact (circle one): Mail Phone Email

Who could we share your protected health information to?

Name: _____ Phone: _____ Relationship_____

Name: _____ Phone: _____ Relationship_____

Insurance:

Subscriber's Name: _____ Subscriber's date of birth: _____

Subscriber's Address: _____

Subscriber's gender: Male Female Relationship to subscriber: _____

To the best of my knowledge the above information is true. If the patient is a minor, I give my permission for treatment. I authorize the release of information needed to process this insurance claim and request payment of medical benefits to be sent to this physician. I agree to fiscally be responsible for the patient's account. It is my responsibility to notify Carrollton Primary Care should this information change.

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any services and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

By signing below, I acknowledge that I have received a copy of the Privacy Practices of ***Carrollton Primary Care***.

Signature of Patient or Responsible party _____Date: _____