

Rocky Mount Family Medical Center

Patient Information: Doctor of Choice Patient Name:_____ First Middle Last Mailing Address:____ Please include PO Box and apartment number County:_____ State:_____ Zip:_____ Home Telephone No.: () -Cell No: () -Marital Status: Married Single Widow Divorce Sex: Date of Birth: Social Security No: Race: Caucasian African-American Hispanic Asian Other Employer: ____ Address Guarantor/Responsible Party Information: (Please fill out if patient is a minor. Note that if you are 18 and/over, you are still responsible for the bill) Full Name: _____ Relationship to patient: Middle Mailing address: _____ Please include PO Box and apartment number, city, state and zip code Sex: M Employer/School: Work Phone: () -**Insurance Information:** Name of Primary Insurance Company: ______ Group Number Policy Number: DOB: ___/___ Secondary Insurance Company Name: ______ Group Number_____ Policy Number: _____

Authorization to release information and to pay benefits to _______. I hereby authorize the physician designate to release information acquired in the course of my examination and treatment. I hereby Assign payment directly to the designated physician for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Date:

Parent/guardian if patient is a minor

DOB: ___/___

Name of Insured: