Cramer Family Clinic℠

Print Form

2301 South Highway 65, Suite 3
Marshall, Missouri 65340

Ph (660) 886-4665 Fax (866) 691-6075

NEW PATIENT INFORMATION

Date: _____

Patient Name: _____

Address: _____ City _____ State _____ Zip _____

Email: _____

Home Phone #: _____ Work Phone: _____ Mobile: _____

☐ Widowed ☐ Divorced ☐ Single ☐ Married Sex: M ☐ F ☐ Date of Birth: _____

Social Security #: _____ Employer: _____ Occupation _____

Spouse Name: _____ Spouse SS#: _____ Spouse Date of Birth: _____

Spouse Employer: _____ Spouse Phone: _____

Emergency Contact: Name _____ Phone _____ Relationship: _____

Where can we contact you to notify you of appointments and test results? _____

In accordance with patient confidentiality and privacy laws, we will need your written permission to discuss appointments, lab results, test results, medical records and your account with anyone other than yourself. Please list below those family members you give permission to access your information.

☐ NO ONE

Name	Relationship	Phone #

Who is financially responsible for Payment of these services? ☐ Self ☐ Spouse ☐ Parent/Guardian

Name _____ Relation _____ DOB _____

Address: _____

City: _____ State: _____ Zip: _____

SS# _____ Employer _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

MEDICAL INSURANCE INFORMATION:

We will be happy to file your insurance claim for medical services rendered as long as you provide us with a current insurance card. If you do not have insurance coverage or your insurance is one that we do not participate with, you will be expected to pay for your office visit at the time services are rendered. If perhaps some other arrangement is desired, please speak to the bookkeeper at this time.

Assignment of Benefits and Authorization To Release Medical Information

I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to my physician/supplier. I authorize any holder of medical information about me to release it to the listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s) any information needed to determine these benefits or the benefits for other related services.

I request payment of authorized medical benefits be made to Cramer Family Clinic. I understand that I am fully responsible for all services and charges, including any balance due after payment of insurance and that insurance does not necessarily pay all charges. I also understand that office fees, including co-pays are due and payable when services rendered. I, the undersigned, authorize treatment by the physicians office.

_____ Signature (if minor, parent or guardian signature)

_____ Date