ROSE AVENUE FAMILY MEDICAL GROUP

Patient Name_____Date of Birth:_____

Sex [ ] Male [ ] Female Social Security #_____

Other Names Used:_____

Street
Address_____

City_____State_____Zip Code_____

Home Phone_____Cell Phone_____Work Phone_____

Telephone # you prefer to be contacted at_____

E-Mail Address_____

Language Spoken_____Ethnicity_____Race_____

Preferred Pharmacy_____Street_____

Names of Relatives that come here	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact_____Emergency Phone #_____

Employer_____Occupation_____

Employer Address_____City_____State_____Zip Code_____

Name of Current Insurance_____

I hereby authorize Rose Avenue Family Medical Group to furnish the above insurance company all medical information which said insurance company may request. I hereby assign to Rose Avenue Family Medical Group all money to which I am entitled for medical and/or surgical expense relative to the service rendered by him, but not exceed my indebtedness to said physician. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to Rose Avenue Family Medical Group for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required. I understand that payment is required at the time services are rendered, unless other arrangements have been made with the office.

Signature_____Date_____
Patient or Authorized Representative