

**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