Today's Date:_____ Chart Number

Welcome to Clayton Medical Associates, P.A.

PATIENT INFORMATION

Last Name:_____ Address:_____

First Name:_____ _____

Middle Initial:_____ State:_____ Zip:_____

Home Phone:_____ Marital Status:_____

Social Security Number:_____ Date Of Birth:_____

Place of Employment:_____ Email Address:

Work Address: _____ _____

Work Phone Number:_____ Cell Phone Number:_____

PARTY RESPONSIBLE FOR BILL (if patient is a minor)

Last Name:_____ Address:_____

First Name:_____ _____

Middle Initial:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Emergency Contact Information

Name:_____

Home Phone:_____

Work Phone:_____

Relationship:_____

I hereby authorize my insurance be paid directly the designated physician or subscriber, realizing that I am responsible for paying non-covered services. I have read and understand the financial payment policy. We require patients to give 24 hours notice when cancelling an appointment. If you fail to cancel your appointment without giving notice a charge will incur. No future appointments will be scheduled without payment of this charge. I also authorize the pertinent medical information to insurance carrier and the appropriate physicians.

_____

Signature Date

I do hereby give the providers of Clayton Medical Associates authorization to examine My child, _____, today, hereafter, and to administer treatment as deemed necessary by the attending physician.

_____ _____

Signature Date

Insurance Information

*Because you have given us your insurance card, a copy is being scanned and will be kept in your file. In addition to this copy, please provide the following information:

Policy Holder Name:

_____

Policy Holder's Social Security Number:

_____

Policy Holder's Date of Birth:_____

Carrier Name:_____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____