HORIZON FAMILY MEDICAL GROUP

ACCOUNT #_____

First Name_____ M_____ Last Name_____

Address_____Apt. #_____

City_____ State_____Zip Code_____

SS#____/____/____ Date of Birth ____/____/____ Age_____Sex____Marital Status_____

Email Address_____ Phone #_____Cell #_____

Emergency Contact_____Phone #_____Cell #_____

Please select a primary care clinician of your choice: _____

Please list any other providers that are currently involved in your care:

_____

Pharmacy _____Location_____

New Government regulations require Medical Offices to ask the following questions -

Language_____Race_____Ethnicity_____Refused_____

PATIENT EMPLOYER:

Occupation_____Business #_____

Company Name & Address_____

MEDICAL INSURANCE INFORMATION:

Primary Insurance _____Secondary Insurance _____Self pay _____

I, undersigned, give my authorization to treat and assign directly to Horizon Medical Group, P.C. all medical benefits, if any otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

SIGNATURE_____ **DATE**_____