

Family Practice of Cadillac, PC

827 E. Division
Cadillac, MI 49601

Patient Information

Account# _____

Patient Legal Name _____ Sex _____

Birthdate _____ Social Security No. _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

e-Mail Address _____

Check Appropriate Box Minor Single Married Divorced Widowed Separated

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____ Relationship _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship _____

Address _____ Home Phone _____

Driver's License No. _____ Social Security No. _____ Birthdate _____

Employer _____ Work Phone _____

Insurance Information

Name of Insured _____ Relationship _____

Social Security No. _____ Birthdate _____ Effective Date _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group Number _____ Plan/Coverage Code _____

Insurance Address _____ City _____ State _____ Zip _____

Insurance Phone _____

Do You Have Any Additional Insurance? Yes No If yes, complete the following.

Name of Insured _____ Relationship _____

Social Security No. _____ Birthdate _____ Effective Date _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group Number _____ Plan/Coverage Code _____

Insurance Address _____ City _____ State _____ Zip _____

Insurance Phone _____

Assignment of Benefits:

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare and any other health insurance to: FAMILY PRACTICE OF CADILLAC. This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. Please make payment of office visit charges at the time of service unless you have make other arrangements with our office.

Signed _____ Date ____ / ____ / ____