

FAMILY DOCTORS OF VICKSBURG PC

13320 N. Boulevard St.

Vicksburg, MI 49097

269-649-2012

FAX 269-649-3752

Today's Date: _____

PATIENT INFORMATION

Fill in all in blanks.

Please Print.

Date of Birth: _____ SSN: _____ Single/Married/Widow/Divorced

Patient's Name: _____ Male or Female
First MI Last (Circle one)

Address: _____
Mailing address City State Zip

Home Phone: _____ Cell Phone: _____

Email (for our patient portal): _____

Employer: _____ Full Time/Part Time Work Phone: _____

Spouse: _____ Date of Birth: _____

Do you have a living will? Yes/No (please ask a receptionist if you would like info)

Emergency Contact and #: _____

Authorization to share verbal information only via phone: (please list all those authorized, including spouse)

Name(s)/relationship: _____

Name(s)/relationship: _____

PRIMARY INSURANCE

Insurance Name: _____ Policy/ID Number: _____

Group Number: _____ Policyholder/Relationship: _____

Employer: _____ Date of Birth: _____ SSN: _____

Address/phone (if different from pt) _____

SECONDARY INSURANCE

Insurance Name: _____ Policy/ID Number: _____

Group Number: _____ Policyholder/Relationship: _____

Employer: _____ Date of Birth: _____ SSN: _____

Address/phone (if different from pt) _____

Do you have other medical coverage? _____

PAYMENT POLICY AND CONSENT FOR TREATMENT

"I authorize Family Doctors and its staff to conduct such exams and treatments as may be necessary for proper health care. All information on this registration and medical history forms is correct to the best of my knowledge. Photocopies of such information and authorizations shall be considered as valid as the originals." Payments of all co pays, deductible and non-covered services is due at the time of service unless prior arrangements have been made with the billing manager. Budget payments can be arranged at the time of service. We bill all insurance companies, but do NOT par with all insurance companies. Participation means we collect only the allowed amount by the insurance company's fee schedule. Please check with the receptionist to make sure we participate with your insurance. If any information is missing/incomplete and results in rejection by your insurance company, the bill for any services will be your responsibility. If you have any laboratory/pathology services performed in our office, an outside lab that will bill your insurance may do the testing. Medical information may be sent to your insurance company upon request for payment determination. I have read the above policies and hereby agree to abide by them. In the event of default, I understand and agree that I am legally liable for all costs of collections, including collection fees, reasonable attorney fees, court costs, and other costs to collect this debt. I request payment be made on behalf to Family Doctors of Vicksburg."

Signature: _____ Relationship: _____