

CONANT MEDICAL GROUP
Personal Information

Patient Name: _____ **Mr Mrs MS Dr**
Last First Middle

Home Address: _____
Street City STATE/ZIP

Birth Date: ____/____/____ **SEX: M F TG OTHER** _____
(mm/dd/yyyy) Social Security Number

Home Phone: _____ **MAY WE LEAVE A MEDICAL MESSAGE ON YOUR ANSWERING MACHINE? YES NO**

Work Phone: _____ **MAY WE LEAVE A MEDICAL MESSAGE ON YOUR ANSWERING MACHINE? YES NO**

Cell Phone: _____ **MAY WE LEAVE A MEDICAL MESSAGE ON YOUR ANSWERING MACHINE? YES NO**

Occupation: _____ **Employer** _____

Current Primary Care Doctor: _____

Significant Other: _____

Emergency Contact: _____
Name Phone Number

Insurance/ Pharmacy Information

Insurance Carrier: _____ **ID/Group #** _____

Policy Holder Name: _____
(If other than patient) Last First Date (mm/dd/yyyy)

Address: _____
Street City/ State/ ZIP

Pharmacy: _____ **Location** _____ **Phone** _____

Medication Allergies: _____

Authorization to Assign Insurance Benefits/ Release of Information: I hereby authorize payment of medical benefits directly to the Conant Medical Group relative to billed medical services provided. I also authorize the release of medical information to the insurance company (payer) relative to claims submitted.

Patient Signature **Date** _____

Consent to Treat:

I hereby voluntarily consent to the rendering of medical care including diagnostic procedures and medical treatment by the clinical care providers of the Conant medical Group.

Patient Signature **Date** _____