TOTAL FAMILY
HEALTHCARE

www.totalfamilyhealthcare.co

PATIENT NAME:____

STREET ADDRESS:____

CITY:______________________________STATE:____ZIP:__________

PHONE:_____________________________OTHER PHONE:___________

BIRTHDATE:_____________AGE: _________M:___F:___MARITAL: S M D

SOCIAL SECURITY NUMBER:____________________________________

EMPLOYMENT:____________________________PHONE:____________

SPOUSE EMPLOYMENT:_______________________PHONE:____________

☐ I give my physician and staff permission/consent to leave a message concerning my medical care and treatment on my home phone answering machine.

☐ I give permission for my physician and/or staff to leave a brief message on my home phone answering machine that the medical practice has called either to confirm an appointment or that I need to call the office back.

☐ I **DO NOT** give permission/consent to leave messages concerning my medical care and treatment on my home phone answering machine.

RELEASE OF INFORMATION AND ASSIGNMENT OF PAYMENT

I authorize Total Family Healthcare, PC to release to my insurance company any and all information regarding my treatment and/or diagnosis of my condition that they may consider appropriate to obtain payment for services rendered to me. I also authorize and request such payment to be made directly to Total Family Healthcare, PC any amounts due me for such medical and/or surgical services.

If I am also a Medicare patient, I request payment of authorized Medicare benefits by made on my behalf to Total Family Healthcare, PC for any services furnished me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for services.

______________________________ _______________
SIGNATURE OF INSURED DATE

____
NAME AND NUMBER **(OTHER THAN SPOUSE)** WE CAN CONTACT IN CASE OF EMERGENCY

____
LAB YOU ARE REQUIRED TO USE/ DATE PHARMACY

____
IF YOU ARE HERE BY REFERRAL; NAME OF REFERRING PHYSICIAN