PRIMARY MEDICAL CARE

270 Cornerstone Drive, Suite 105
Cary, NC 27519
(919) 460-7676

PATIENT INFORMATION

Last Name _____ **First Name** _____ **Middle Int.** _____

Street Address _____ **Apt #** _____ **City** _____ **State** _____ **Zip** _____

Sex Fema **Employed** ☐ Yes ☐ No **Employer/School** _____

Home Phone _____ **Work Phone** _____ **Cell Phone #** _____

Date of Birth Ja 01 _____ **SSN #** _____ **E-Mail Address** _____

Spouse _____ **Work Phone #** _____ **Cell Phone #** _____

Spouse's Employer _____ **Address** _____ **Phone #** _____

Parent/Guardian _____ **Address** _____ **Phone #** _____

Nearest Relative/Friend _____ **Home Phone #** _____ **Cell Phone #** _____

Pharmacy Name _____ **Pharmacy Phone #** _____

How did you hear about out office? Ins. Carrier ☐ **Ad- Where?** _____ **Another Patient/Family Member-Name** _____

INSURANCE POLICY HOLDER INFORMATION

(You must provide an insurance card for verification purposes.)

PRIMARY INSURANCE:
Are you the Policy Holder? ☐ **Yes** ☐ **No (If not please complete below information)**
Please check: ☐ **Spouse** ☐ **Dependent.**

Insurance: Aetna ☐ BCBS ☐ Cigna ☐ Medcost ☐ PHCS ☐ United Healthcare ☐ No Insurance ☐

Policy Holder Last Name _____ **First Name** _____ **Middle Int.** _____

Street Address _____ **Apt #** _____ **City** _____ **State** _____ **Zip** _____

SSN # _____ **D.O.B** Ja 0 _____ **Employer** _____

Policy ID # _____ **Group #** _____ **Effective Date** Jan 0 _____

SECONDARY INSURANCE: **We do not file secondary insurance.**

Consent for Treatment: The undersigned hereby consents to examination and treatment of the patient by the physician(s) and to the performance of any surgical or diagnostic procedure, which is deemed necessary including HIV testing.

Authorization to Release Information: I hereby authorize the release of medical information necessary for the purposes of determining eligibility for payment of insurance benefits or to a physicians office to which I have been referred to as a result of my care at this facility.

Financial Responsibilty: I hereby authorize my insurance company to send all payments for medical services rendered to me (or my dependents) directly to Primary Medical Care. I understand that I am responsible for all services not covered by my health plan. Any balances due should be paid when the first statement is received. If insurance benefits are denied, I understand that I am responsible for for the balance due plus any court costs, attorney's fees, or collection agency fees to collect the outstanding balance. If my account is turned over to a collection agency, I understand that my account will be considered "inactive" until such time as the past due balance has been paid and that I may be discharged from the practice. Primary Medical Care reserves the right to charge for missed appointments and physicals.

PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE
We accept Cash, Checks, Visa, Discover or MasterCard

Patient/Parent Signature _____ **Date** _____