ELIZABETHTOWN FAMILY HEALTH CENTER

*Please **PRINT** all Information*

PATIENT INFORMATION

Date:____/____/_____ Social Security #:_____-____-_____ Birthdate:_____/_____/_____

Name:_____
First Middle Last

Address:_____
Number Street Apt# City State Zip Code

Sex: Male / Female Marital Status: Single / Divorced / Married / Widowed / Seperated

Home Ph #: (_____)-_____-_____ Cell Ph #:(_____)-_____-_____ Work Ph #(_____)-_____-_____

EMPLOYER INFORMATION

Employer:_____ Work Phone #:(_____)-_____-_____

Address:_____
Number Street City State Zip Code

NEXT OF KIN

Spouse Name:_____

Father's Name (If Minor):_____

Mother's Name (If Minor):_____

EMERGENCY INFORMATION

Name:_____ Relationship_____

Address:_____
Number Street City State Zip Code

Home Phone #: (_____)-_____-_____ Cell Phone #:(_____)-_____-_____

Name:_____ Relationship_____

Address:_____
Number Street City State Zip Code

Home Phone #: (_____)-_____-_____ Cell Phone #:(_____)-_____-_____

ALL PATIENTS (Including Medicare):

I understand that my health insurance may have certain exclusions and limitations, relating to authorization requirements, non-covered services, cosmetic surgery, frequency of testing, visits and supplies. Since I have chosen to obtain services and/or supplies, I agree to be financially responsible for any and all related charges, if not covered by my insurance.

SIGNATURE:_____ _____**DATE:**____/____/_____

FOR MEDICARE or Medicare ADVANTAGE PATIENTS ONLY:

I request that payment of authorized Medicare benefits be made on my behalf to Elizabethtown Family Health Center, a division of Physicians' Alliance, Ltd., for any services furnished me by Patrick E. Gilhool D.O., Michael J. Leser D.O. Miles G. Newman D.O. Mark E. Morgan D.O. Mary S. Ginder CRNP. or their associates.

I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services.

SIGNATURE:_____ **DATE:**____/____/_____