MIDDLETOWN FAMILY CARE ASSOCIATES, LLC

DEMOGRAPHIC INFORMATION

Today's Date	First Name		Last Name	MI	Gender
Date of Birth	Age	Social Security # (Last 4 Digits)	Occupation	Marital Status	
Street Address			City, State	Zip Code	
Cell Phone #		Home Phone #		Work Phone #	
Email Address					

EMERGENCY CONTACT

Name:		Relation to Patient
Home Phone #	Cell Phone #	Work Phone #

PHARMACY

Name:	Main Phone #	Location #

INSURANCE INFORMATION

COPY OF INSURANCE CARD & PHOTO ID

If your insurance coverage is under another person's name, please note their name and date of birth:

Name of Policy Holder	**Date of Birth**

RESPONSIBLE PARTY

Last Name			First Name	MI	Gender
Date of Birth	Age	Social Security #(Last 4 Digits)	Occupation	Marital Status	
Street Address			City, State	Zip Code	
Cell Phone #		Home Phone #		Work Phone #	
Email Address					

Please initial and sign at the bottom:

_____ **Authorization and Assignment of Benefits:** I hereby give permission to Middletown Family Care Assoc., LLC and its employees, agents, and medical providers to release medical information to health plans, health organizations, governmental agencies, and other entities charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me to be directed to Middletown Family Care Assoc., LLC. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I understand that any or all of my medical information may be electronically submitted to any or all treating providers, hospitals, and/or health care entities. I permit a copy of this authorization to be used in place of the original.

_____ **Financial Policy Acknowledgement:** I hereby acknowledge that I have received and reviewed the FINANCIAL POLICY of Middletown Family Care Assoc., LLC. I understand that it is my responsibility to provide Middletown Family Care Assoc., LLC with my current demographic, insurance, and medical information.

_____ **HIPAA Privacy Acknowledgement:** I hereby acknowledge that I have received and reviewed the NOTICE OF THE PRIVACY PRACTICES from Middletown Family Care Assoc., LLC.

Patient or Guardian Signature:_____ **Relationship:** _____ **Date:** _____