Montgomery Internal Medicine Group

Patient's Name: _____ Date of Birth: _____ Sex: _____

Race: _____ Ethnicity: _____

Social Security # (Required for billing): _____

Home Phone#: _____ Work #: _____ Cell #: _____

Home Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Date of Birth: _____ Work #: _____

Person to Notify if other than Spouse: _____ Relationship: _____

Address: _____ Phone #: _____

Who Recommended MIMG to you: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Name of Policy Holder: _____ Policy / I.D. #: _____

Secondary Insurance Company: _____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Blue Shield, HMO's and Commercial Insurance to Montgomery Internal Medicine Group, P.A. I understand that I am financially responsible for all charges whether or not covered by said insurance, including lab charges. I hereby authorize said assignee to release any information necessary to secure payment.

Signed _____ Date _____