NORTHERN MEDICAL GROUP
FAMILY MEDICINE
a department of Northern Hospital

PATIENT INFORMATION

Last Name	First Name	Middle Name	Birth Date
Address	City	State	Zipcode
Home phone	Cell phone	Email	❑ I decline to provide my email
Who referred you to this office?			
Gender ❑ Male ❑ Female	Race (optional)	Ethnicity	Preferred language
Social Security Number	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed		
Medicare Number	Preferred Pharmacy		
Health Insurance Company	Insurance Number		
Spouse's Name	Birth Date	Phone	Work Phone
How would you prefer to be contacted? ❑ Phone ❑ Cell phone ❑ Voice mail ❑ Email ❑ Mail			

EMPLOYER INFORMATION (Adult)

Patient's Employer	Phone		
Employer's Address	City	State	Zipcode
Spouse's Employer	Phone		
Spouse's Employer's Address	City	State	Zipcode

GUARANTOR INFORMATION

Guarantor's Full Name	Patient's Relationship to Guarantor			
Home phone	Cell phone	Work phone	Gender ❑ Male ❑ Female	
Guarantor's Address	City	State	Zipcode	
Guarantor's Birth Date	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed			

EMERGENCY CONTACT

Name of Person	Relationship		
Address	City	State	Zipcode
Home phone	Work phone	Cell phone	

PHONE NUMBERS:
Providing us with a wireless telephone number or a landline number gives us your permission to call that number.

MEDICARE AUTHORIZATION:
I designate and authorize Medicare payments directly to Northern Medical Group Family Medicine for any benefits payable for services rendered.

AUTHORIZATION TO RELEASE INFORMATION AND BENEFITS:
I hereby authorize Northern Medical Group Family Medicine to release any medical information to the insurance company (s) that I designate, and to their agents, to determine benefits or benefit related services. I authorize payment directly to Northern Medical Group Family Medicine for any benefits payable for services rendered. I understand that regardless of whether any insurance coverage is applicable, I am responsible for this account in full, including any copay amounts or deductibles due at the time of my visit.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:
I acknowledge that I have received a copy of Northern Medical Group Family Medicine (Northern Hospital of Surry County) Notice of Privacy Practices.

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY OR OTHER AUTHORIZED REPRESENTATIVES:
I authorize the release to or discussion of my protected health information to the following people:
Name(s)/Relationship(s): _____

CONSENT TO TREATMENT:
I authorize Northern Medical Group Family Medicine to treat me as a patient, and I authorize such care, treatments and/or diagnostic studies to be performed as are deemed necessary by my healthcare Provider.

Signature of Patient or Patient's Representative & Relationship **Date** **Time**