Montrose Family Practice

525 N. Cleveland-Massillon Road, Suite 203

Akron, OH 44333

Patient Name: ____

(Last) (First) (Middle Initial)

Address: ____

City: ______________________________ State: ____________ Zip: _____________

Patient Sex M F Birthdate: ____/____/_____ Marital Status: ______ Social Security: ______________

Home Phone # ( ) __________________ Cell Phone # ( ) _______________ Preferred # H / C

Email Address: ____

Pharmacy: ____________________________________ Phone # ( ) _________________

Family Physician Name: ___________________________ Phone # ( ) _________________

Employer: ____________________________________ Phone # ( ) _________________

Spouse's Name (if Applicable): ______________________ Spouse's Birthday: ____/____/____

Spouse's SS#: __________________ Spouse's Employer: ____________________________

Relative/Friend (other than spouse) Name: ______________________________________

Relationship: ________________________ Phone # ( ) __________________________

PRIMARY INSURANCE

Insurance Name: ________________________________ Policy #: ____________________

Address: ______________________________________ Group #: ____________________

City, State, Zip: ________________________________ Effective Date: ________________

Policyholder Name: _____________________________ Policyholder DOB: _____________

Policyholder SSN: ________________________ Relationship to patient: ________________________

SECONDARY INSURANCE

Insurance Name: ________________________________ Policy #: ____________________

Address: ______________________________________ Group #: ____________________

City, State, Zip: ________________________________ Effective Date: ________________

Policyholder Name: _____________________________ Policyholder DOB: _____________

Policyholder SSN: ________________________ Relationship to patient: ________________________

I hereby permit Montrose Family Practice to release any information acquired in the course of my examination or treatment required to process this claim. I also authorize treatment by the physicians and staff and personnel of Montrose Family Practice. I hereby agree to pay any Copays, Deductibles, and amounts over UCR, and/or excluded charges, exceeding payments from insurances with whom Montrose Family does not except assignment with, and/or all Copays and Deductibles with those they do. I hereby request my insurance carrier to pay on my behalf insurance benefits to Montrose Family Practice for services rendered. I understand this authorization will be effective until revoked in writing. Montrose Family Practice fees are not established by insurance companies I am responsible for my account.

Signed: ____ Date: ________________