OAK GROVE FAMILY MEDICAL CLINIC

ACCOUNT INFORMATION

❒ Male ❒ Female

Patient Name: _____
Last First Middle

Mailing Address: _____

City, State, Zip: _____

Employer/School: _____ **Pt. Email:** _____

Preferred Phone: _____ **Optional Phone:** _____

Patient SS#: _____ **Marital Status:** _____ **Date of Birth:** _____

Guardian Info: _____ **Date of Birth:** _____

SS#: _____ **Employer:** _____ **Work Phone:** _____

Spouse Name: _____ **Date of Birth:** _____

SS#: _____ **Employer:** _____ **Work Phone:** _____

Emergency Contact: _____ **Phone #:** _____
Name Relationship

Preferred Pharmacy: _____ **Mail Order:** _____

Race: ❒ Asian ❒ Black ❒ Caucasian ❒ Asian Pacific ❒ Native American ❒ Hispanic

❒ Native Alaskan ❒ Native Hawaiian ❒ Other _____

Primary Insurance: _____ **Employer:** _____

Group #: _____ **ID#:** _____

Policyholder: _____ **DOB:** _____

Secondary Insurance: _____

Group #: _____ **ID#:** _____

Policyholder: _____ **DOB:** _____

Referred By: _____

AUTHORIZATION FOR TREATMENT OF A MINOR

I HEREBY AUTHORIZE THE ABOVE DOCTOR/DOCTORS TO PROVIDE SUCH MEDICAL SERVICES INCLUDING SURGERY, IF NECESSARY, EITHER REGULAR OR EMERGENCY, AS MAY BE DETERMINED TO BE IN THE BEST INTEREST OF THOSE MEMBERS OF MY IMMEDIATE FAMILY AS LISTED ABOVE, WHO ARE MINORS. THIS AUTHORIZATION SHALL CONTINUE AND BE IN FULL FORCE AND EFFECT UNTIL REVOKED IN WRITING BY ME.

_____ _____
PARENT OR GUARDIAN DATE

INSURANCE AUTHORIZATION

I HEREBY AUTHORIZE THE ABOVE DOCTOR/DOCTORS TO FURNISH THE INSURED'S INSURANCE COMPANY ALL INFORMATION WHICH SAID INSURANCE COMPANY MAY REQUEST CONCERNING MY PRESENT ILLNESS OR INJURY. I HEREBY ASSIGN TO THE DOCTORS ALL MONEY TO WHICH I AM ENTITLED FOR MEDICAL AND/OR SURGICAL EXPENSE RELATIVE TO THE SERVICE PERFORMED FROM TIME TO TIME, BUT NOT TO EXCEED BY INDEBTEDNESS TO SAID PHYSICIANS AND SURGEONS. IT IS UNDERSTOOD THAT ANY MONEY RECEIVED FROM THE ABOVE NAMED INSURANCE COMPANY OVER AND ABOVE MY INDEBTEDNESS WILL BE REFUNDED TO ME WHEN MY BILL IS PAID IN FULL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO SAID DOCTOR FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

_____ _____
PATIENT SIGNATURE OR RESPONSIBLE PARTY DATE