Preston Medical Associates
Patient Information

Date:_____ MR#(for office use only)_____

Name:_____
Last First M
Address:_____
Street Apt. City State Zip

Email Address:_____How did you hear about us?_____

Martial Status: M/S/W/D/Sep Race: Cauc/Black/Asian/Other Birthdate:_____

Home Phone_____Work Phone_____Cell Phone/Pager_____

Social Security #_____Occupation_____Employer_____

Employer Address_____
Street City State Zip

Insurance Policy Holder:_____

Responsible Paty:_____

Address:_____
Street City State Zip

Employer of Responsible Party:_____

Address:_____
Street City State Zip

Responsible Party Social Security #:_____

Next of Kin/Emergency Contact:_____Relationship to Patient:_____Phone_____

Medical Insurance Company (Primary)_____Group #_____
Effective Date:_____Address_____Policy#_____
In whose name is the policy?_____

In order to control your cost of billings, we request that our charges for office visits be paid at the time of service. If it is necessary to arrange a payment plan, prior arrangements should be made. We accept Master card and Visa. Insurance claims are file as a courtesy to our patients.

Authorization to pay benefits to physician. I hereby authorize payment to the undersigned physician of the surgical/medial benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charges for those services._____
Patient Signature

Authorization to release information: I hereby authorize Preston Medical Associates, PA to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers, or others involved in processing and collection of this claim._____

Patient Signature

Guaranty of Accuracy, I guarantee that I have provided Preston Medical Associates, PA with all insurance information and that it is accurate and complete. _____

Patient Signature