New Albany Medical Group
Patient Information

Patient Name: _____ Birthdate: _____

Mailing Address: _____ Physical Address: _____

City, State, Zip:_____City, State, Zip: _____

Home Phone: _____Cell Phone:_____ SSN.: _____ Sex: □ Male □ Female

Email address: _____

Employer: _____Work Phone: _____

Spouse's Name: _____ Employer: _____W. Phone: _____

Spouse's Date of Birth: _____ Spouse's SSN:_____

Emergency Contact: _____ Relation: _____ Phone: _____

Pharmacy Preference: _____ Phone: _____

Responsible Party (if other than patient)

Name: _____ Relationship: _____

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

Phone: _____ Cell Phone: _____ Employer: _____

Soc. Sec. Number: _____ Date of Birth: _____

Insurance Information (Please present your insurance card for photocopying)

Primary: _____ Insured's Name: _____

Secondary: _____ Insured's Name: _____

I hereby authorize and assign payment of insurance/Medicare/Medicaid benefits to New Albany Medical Group and the release of any information needed for the purpose of evaluating and administering claims for insurance benefits. A photocopy of this assignment is to be considered as valid as an original.
I understand that I am ultimately responsible for any and all charges associated with my account ant that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of the balance due. I also understand that my account with this provider is considered an open account.
Authorization is hereby given for any medical treatment ordained advisable or necessary by the staff of New Albany Medical Group. I also acknowledge that no guarantee or assurance has been made as to the results of such treatments, procedures, or examinations.
I hereby authorize providers at this clinic to access my Rx history through ePrescribing.
This authorization is good for my lifetime unless revoked by me in writing.

Signature: _____ Relationship: _____

Date: _____