MEDCENTRAL

1720 Westchester Dr.
High Point, NC 27262
(336) 883-4296

2401 Hickswood Rd., Suite 106
High Point, NC 27265
(336) 885-9675

PATIENT INFORMATION

Registrar's Initials:_______ Date:___________________ Physician (If Any): ______________________________________

Symptoms of Illness/Injury:____ Date Symptoms Began:_______________

Method of Payment: Cash_____ Check_____ MasterCard_____ Visa_____ Amex______ Discover_____

____

A. Patient's Full Legal Name: ____

Address: ____

Street **City** **State** **Zip Code**

Home Phone: ( )________________ **Cell Phone:**__________________ **Birth Date** _________________

Occupation:____ **Sex:** _______**F** _______**M**

Marital Status: Single_____ **Married**_____ **Widowed**_____ **Divorced**_____ **Separated**_____

Work Phone: ( )_________________ **Social Security No.:**___________________________

Patient's School: ____

Employer: __________________________________ **Address:** ___________________________________

Spouse's Name:___________________________________ **Spouse's Birth Date** _____________________

Spouse's Social Security No.:_______________________ **Employer:**_____________________________

Work Phone: ( )________________________ **Occupation:**___________________________

B. Emergency Contact (not living with you): ____

Relationship: _________________________________ **Home Phone: ( )**_______________________

Alternate Phone: ( )__________________________

PLEASE CONTINUE ON OTHER SIDE. IF PATIENT IS UNDER 18 YEARS OLD, PLEASE COMPLETE SECTION C.

C. Parent/Guardian Information

Name:____

Address (if different from above):____

Street **City** **State** **Zip Code**

Home Phone: ( ) ____________________ **Birth Date:**________________ **Age:**_____________

Occupation:____ **Sex:** _____**F** _____**M**

Marital Status: Single _____ **Married** _____ **Widowed** _____ **Divorced** _____ **Separated**_____

Work Phone: (   ) _____________________ **Social Security #:** ___________________

Employer: __________________________________

Address_____________________________

Spouse's Name: ___________________________________ **Spouse's Birth Date**_______________

Spouse's Employer: _____________________________ **Work Phone: (   )**___________________

Spouse's Occupation: ________________________________

Do you have insurance? ___________Yes ____________No

*****Please have your insurance card and photo ID ready to be copied.*****

PRIMARY INSURANCE CO.:____

Policy Holder's Name:_____________________________ Social Security #________________

Policy Holder's Employer:____

Date of Birth_________________ Sex: _____Male _____Female

Relationship to Patient: _____Self _____Spouse _____Child _____Other

Address of Primary Insurance Co.:____

Street or Box Number City State Zip Code

Group #________________________ ID #__________________________

SECONDARY INSURANCE CO.:____

Policy Holder's Name:_____________________________ Social Security #________________

Date of Birth_________________ Sex: _____Male _____Female

Relationship to Patient: _____Self _____Spouse _____Child _____Other

Address of Secondary Insurance Co.:____

Street or Box Number City State Zip Code

Group #________________________ ID #__________________________

Please indicate if you have other insurance coverage:___________________________________

The undersigned makes the following acknowledgments and agreements regarding treatment to be provided to the patient whose name appears above:

1 – **Consent to treatment: I** consent to any medical or surgical treatment rendered to the patient under general or special instructions of the physician. I certify that no guarantee of assurance has been made to me as to the results which may be obtained.

2 – **Release of medical information: I** authorize the release of any medical or other information from this provider and other providers necessary to process a health insurance claim or to provide treatment.

3 – **Assignment of benefits: I** authorize payment of medical benefits to MedVentures, LLC DBA MedCentral.

I certify that the information given at the time of registration is correct. I understand that I will be financially responsible for all charges in full at the time I am given treatment unless otherwise discussed before I am seen. I understand I am financially responsible to MedCentral for charges not covered by insurance.

______________________________________ ______________________________

Signature of Patient or Legal Representative Date

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