CROSSROADS MEDICAL GROUP PLLC

Last Name _____ First Name _____ Middle Name _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

☐ **OK to leave a message** ☐ E-mail address _____

Date of Birth _____ ☐ Male ☐ ☐ Female Social Security Number _____

Employer _____ Address _____ Phone Number _____

Pharmacy of Choice _____ **City** _____

**********Insurance Information**********

Primary Insurance Subscriber Information: Insurance Company _____

Insured's Name _____ Date of Birth _____ Subscriber ID Number _____

Secondary Insurance Subscriber Information: Insurance Company _____

Insured's Name _____ Date of Birth _____ Subscriber ID Number _____

**********Emergency Contact**********

Name _____ Relationship _____ Phone Number _____

City _____ Street Address _____ State _____ Zip _____

RELEASE OF INFORMATION

☐ ☐ **Yes**, I give permission to discuss my medical conditions(s), my treatment, and information regarding my appointments with the following individuals:

Name _____ Relationship _____

Name _____ Relationship _____

☐ **No**, the staff may not divulge information regarding my medical care or treatment to anyone other than me.

My signature below indicates that I have been given the opportunity to review a current copy of the Crossroads Medical Group, PLLC "*Notice of Privacy Practices.*"

Patient or legally authorized signature _____ Date _____ Relationship to patient _____