CROSSROADS
Medical Group

_____ _____ _____
Last Name First Name Middle Name

_____ _____ _____ _____
Street City State Zip

_____ _____ _____
Home Phone (Primary? ☐) Cell Phone (Primary? ☐) Work Phone (Primary? ☐)

OK to leave a message ☐ E-mail address_____

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

_____ _____
Employer Address

_____ _____ _____
City State Zip

Pharmacy of Choice_____

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

Please tell us how you heard about us (Check all that Apply? Website☐, Email☐, Billboards☐, Direct Mail☐, Walk-In☐, Internet☐, Referral from an existing patient☐?