



Family Medicine Center
 1601 Owen Drive
 Fayetteville, NC 28304
 910-678-0100
 Fax 910-678-0115

Specialty Medicine Center
 1601-A Owen Drive
 Fayetteville, NC 28304
 910-678-7287
 Fax 910-678-7274

Patient Information

Patient Account #: _____ SSN: _____ - _____ - _____ How did you Hear about us? _____
 Last Name: _____ First: _____ MI: _____
 Street Address: _____ Apt: _____
 City: _____ State: _____ Zip: _____
 Date of Birth: _____ Age: _____ Sex: **M or F** Marital Status: _____ Language Preference: _____
 Home Phone# :() _____ Cell Phone # :() _____
 Work Phone # :() _____ Employer: _____
 Emergency Contact Name: _____ Phone# :() _____
 Relation to Patient: _____
 Email: _____ Preferred communication method: _____

Race: Black White
Asian/Pac. Islander
Am. Indian Hispanic
Other _____

Other Family Members

Name	Age	Name	Age

Responsible Party(Bill will be sent to this person)

Last Name: _____ First: _____ MI: _____
 Street Address: _____ Apt: _____
 City: _____ State: _____ Zip: _____
 Date of Birth: _____ Age: _____ Sex: **M or F** Marital Status: _____
 Home Phone# :() _____ Cell Phone # :() _____
 Work Phone # :() _____ Employer: _____
 SSN: _____ - _____ - _____ Relationship to Patient: _____

Insurance Information (Please present you insurance card to the receptionist for copying)

Primary Insurance Insurance Company: _____
 Policy Holder _____ DOB: _____ Sex: **M or F**
 SSN: _____ - _____ - _____ Relationship to Patient: _____
 Subscriber ID #: _____ Employer: _____
 Policy #: _____ Group #: _____

Secondary Insurance Insurance Company: _____
 Policy Holder _____ DOB: _____ Sex: **M or F**
 SSN: _____ - _____ - _____ Relationship to Patient: _____
 Subscriber ID #: _____ Employer: _____
 Policy #: _____ Group #: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Patient Signature: _____ **Date:** _____
Verified by: _____ **Date:** _____

