Memorial Medical Group
a service of Comanche County Memorial Hospital

Patient Information:

Name: _____
Last First Middle

Former Last Name (if recently married):_____

Address: _____
Number or Rt Street City State Zip Code

Home Phone: _____ Cell: _____ Work: _____
Ext

Referring Provider: _____
Name Address Phone

Date of Birth: _____ Sex: ___ M ___ F Marital Status: S M D W LS* (*Legally Sep.)
Month/Day/Year (Circle One)

SSN _____ - _____ - _____ eMail: _____

Parent Information (For Minors Only):

_____
Mother Name Phone Number email

_____
Father Name Phone Number email

Employer:_____
Name Address Phone

Emergency Contact: _____ Relationship: _____
Name Address Phone

Race: ___Asian ___Native Hawaiin ___Black or African American ___White ___Hispanic ___Other ___Other Pacific Islander

Ethnicity: ___Hispanic or Latin ___Not Hispanic or Latin Language_____

Pharmacy Preference: _____
Name Location Phone

Pharmacy Mail Order Co.:_____
Name Phone Fax

Pharmacy Mail Order Member ID: _____

Guarantor Information:

Name: _____ DOB: _____ SSN: _____-_____-_____
Last First MI Month/Day/Year

Phone: _____ eMail: _____ Sex: ___ M ___ F
Ext

Address: _____
Number or Rt Street City State Zip Code

Employer:_____
Name Address City State Zip Code

Guarantor's Work Phone:_____
Ext

Guarantor's Relationship to Patient (Circle one):

Self Spouse Natural child Employee Unknown Life Partner Other

Insurance Information:

Primary Insurance: _____ Certificate #:_____ Group #: _____

Policy Holder Name: _____ Policy Holder SSN: _____ - ____ - _____

Policy Holder Date of Birth: _____ Policy Holder Relationship to Patient _____

Secondary Insurance:_____ Certificate #:_____ Group #: _____

Policy Holder Name: _____ Policy Holder SSN: _____ - ____ - _____

Patient Privacy:

I have received a copy of Comanche County Memorial Hospital Notice of Privacy Practices _____
Please Initial

Do you prefer to be contacted by: ____Home Phone ____Cell ____Work ____eMail _____Text

May we leave a message regarding appointment confirmation or for you to call the office back?

___Yes ___No Comments:_____

Do you have an Advanced Directive? ____Yes ____No

I understand that I am responsible for the payment of services. Insurance will be filed as a courtesy; however, after 60 days if no response is received, I understand that I could be responsible for charges. I understand that I am responsible for payment of any amount that is not covered by insurance. I also authorize the release of any medical information necessary to process insurance claims for services rendered.

Date_____ Signed _____