Medoff Medical
Treating the Digestive System by Caring for the Patient

PATIENT CONTACT & INSURANCE INFORMATION

GREENSBORO ENDOCRINOLOGY

Patient Name: _____ Patient Chart Number: _____
Last First Middle Initial

Address: _____ Email Address: _____

City: _____ State: _____ Zip: _____ Employer: _____

Home Phone: ( )_____ Work: ( )_____ Ext.: _____ Cell: ( )_____

Social Security No.: _____ Date of Birth: _____ Sex: _____

Referring Physician: _____ Primary Physician: _____

Known Allergies: _____ Preferred Language: _____

Ethnicity (Please Circle): Hispanic Not Hispanic

Race (Please Circle): American Indian Alaska Native Asian Black Native Hawaiian White Refuse to Answer Do not know

Marital Status? (Please Circle): Single Married Separated Widower Widow

Person Responsible for Payment: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Social Security No.: _____

Home Phone: ( )_____ Work: ( )_____ Ext.: _____ Cell: ( )_____

Primary Ins. Co.: _____ Policy Holder's Name: _____

Policy No.: _____ Group No.: _____

How is the patient related to Policy Holder? (Please Circle): Effective Date: _____
Self Husband Wife Male Child Female Child

Secondary Ins. Co.: _____ Policy Holder's Name: _____

Policy No.: _____ Group No.: _____

How is the patient related to Policy Holder? (Please Circle): Effective Date: _____
Self Husband Wife Male Child Female Child

Preferred Pharmacy Name & Location: _____ Pharmacy Phone #: ( )_____

Primary Emergency Contact: _____ Relationship: _____

Phone Numbers: _____

Secondary Emergency Contact: _____ Relationship: _____

Phone Numbers: _____

THIS FORM MUST BE SIGNED BEFORE TREATMENT IS PROVIDED. THANK YOU.

Fees for Professional Services are payable at the time of service rendered. We accept cash, check, Mastercard, or Visa. HMO/PPO copays are to be paid at the time of service. If you have medical insurance, we will file your claim. It remains your responsibility to contact your agent or company if you are not satisfied with the insurance payments. If this account is assigned to an attorney as in a liability case, you are still responsible for payment.

I Authorize the release of my records to my insurance company or attorney to facilitate payment and/or processing of my claim. I also authorize release of my medical history and/or records to any pharmacy or health care provider to whom I may be referred for a second opinion, for a consultation, for therapy or for treatment. I also authorize obtaining any medical records from health care providers involved in my treatment. I hereby assign all insurance benefits, medical, liability or otherwise to Medoff Medical if any balance is due.

I further understand that because of the nature of this practice, a physician may not be available at all times.

Signed: _____ Date: _____
(Parent/Guardian, if patient is a minor)