Date: _____

Name: _____ SSN #: _____ DOB: _____

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

Phone #: _____ Email: _____ Sex: _____ Race: _____

Marital Status: Single Married Divorced Widowed Separated

Employer: _____ Employer Phone # _____

Spouse' Name: _____ Cell Phone #_____

In case of Emergency Contact (NOT LIVING WITH YOU): Name: _____

Phone #: _____ Relationship: _____

Insurance Company: _____ Insured's Name: _____ DOB_____

Policy or ID #: _____ Relationship to Patient: _____

Secondary Insurance: _____ Insured's Name_____

Policy or ID #: _____ Relationship to Patient: _____

Pharmacy: _____ City: _____

**********__MINORS ONLY__**********

Mother's Name: _____ Address: _____

SSN #: _____ DOB: _____ Phone: _____

Father's Name: _____ Address: _____

SSN #: _____ DOB: _____ Phone: _____

**********__AUTHORIZATION AGREEMENT__**********

I hereby authorize MegMed Health, LLC for the purpose of billing to furnish medical information necessary to insurance carriers concerning any illness/accident for which I am treated in this clinic, and I hereby assign to MegMed Health LLC all payment for medical services rendered. I understand that I am financially responsible for charges whether or not covered by insurance, and if I fail to pay any amount due I will be responsible for all collection fees, court cost, attorney fees, and any other charges incurred in the collection of the balance due. I understand I will be billed for services performed.

Signature: _____ Date: _____