Patient Information Form:

Print Form

Date Completed:

Carroll Family Healthcare, Inc.

635 Locust St., PO Box 548
Malvern, Ohio 44644
Phone: 330-863-9061
Fax: 330-863-6492
www.malverndocs.com

Patient Name:
Address:
City:
Zip Code:
Social Security #:

Date of Birth:

Gender:

Marital Status:

Contact Information:

Home phone:
Work Phone:
Cell Phone:

E-mail Address:

Would you be interested in receiving results via e-mail?

Employer Information:

Patient Employer:

Employer Phone:

Spouse's Information (If applicable):

Spouse's Name:

Spouse's Employer:

Spouse's Social Security:

Spouse's Date of Birth:

Contact person designated to receive your health care information on your behalf (optional):

Name:
Phone:
Relationship:

Our office HIPPA policy regarding how we protect your health information is posted on our web site. If a paper copy of this document is needed, it will be provided to you. If you do NOT designate a contact person, our office will only be able to communicate information such as test results, appointment times, etc. with YOU directly.

Insurance Information:

Responsible Party Information (Person responsible for payment):

Name: _____ **Birth Date:** _____

Address: _____ **Home Phone:** _____

City: _____ **Zip:** _____ **Cell Phone:** _____

If child of divorced parents... Name of custodial parent: _____

Phone of custodial parent: _____

Insurance Information - Primary Insurance:

Insured's Name: _____ **Relationship to Patient:** _____

Name of Insurance: _____ **Insured's Employer:** _____

Insured's Social Security #: _____ **Insured's Birth Date:** _____

Insurance Information - Secondary Insurance:

Insured's Name: _____ **Relationship to Patient:** _____

Name of Insurance: _____ **Insured's Employer:** _____

Insured's Social Security #: _____ **Insured's Birth Date:** _____

Insurance Information - Tertiary Insurance:

Insured's Name: _____ **Relationship to Patient:** _____

Name of Insurance: _____ **Insured's Employer:** _____

Insured's Social Security #: _____ **Insured's Birth Date:** _____

Your signature below attests that you have had the opportunity to read our HIPPA policy and gives us permission to communicate with your contact person if you designated one above. Your signature also gives us permission to file your insurance information and use your health information for purposes of obtaining payment for your office visits.

Signature: _____

Print Form

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