KELLUM MEDICAL GROUP, PA

Family Practice * Pediatrics * Lifelong wellness

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Patient Name (First Name, MI, Last Name):_____

Date of Birth: _____ Social Security: _____-_____-_____

Gender: (Male\Female) Marital Status: _____

Address: _____

City, States, Zip Code: _____

Phones (Home, Cellular, Work): _____

E-mail:_____ Preferred language: _____

Race: O Asian O Black or African American O White O Other: _____

Ethnicity: O Hispanic\Latino O Non-Hispanic\Latino O Unspecified

Please insure all information is correct and valid

PERSON RESPONSIBLE FOR PAYMENT:

Responsible Party Name (First Name, Initial, Last Name): _____

Date of Birth: _____ Social Security: _____-_____-_____

Address: _____ Gender: (Male\Female)

City, States, Zip Code: _____

Phones (Home, Cellular, Work) _____

EMERGENCY CONTACT: (List someone who has a different phone number)

Name: _____

Phone: (Home, Cellular, Work) _____

Relationship to patient: _____ Parent _____ Sibling _____ Child _____ Spouse _____ Friend____

Other/specify: _____

Authorization and acknowledgement:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly To Kellum Medical Group. I understand that I am financially responsible for any balance. I also authorize Kellum Medical Group or insurance company to release any information required to process any claims.

_____

Patient or Parent signature Date

FOR OUR MEDICARE PATIENTS: Medicare pays 80% of the amount they approve after you have met you deductible. You are Responsible for you deductible and the remaining 20%. If you have insurance that covers the remaining 20%, provide us with the Information, even if you signed up for Medicare Crossover.