FONTICIELLA MEDICAL CLINIC, INC.
4000 LINWOOD DRIVE SUITE G
PARAGOULD AR 72450
TELEPHONE: 870-236-6930 FAX: 870-239-8065

Patient Name: _____ Date of birth: _____

Marital Status: Single Married Divorced Widowed Social Security Number: _____

Ethnicity/Race: _____ Primary Language: _____

Mailing Address: (where you receive mail) _____

_____

Home Phone: _____ Cell: _____Work Phone: _____

Message Number: _____ Email Address: _____

Employer Name & Address _____

Primary Insurance: _____ Subscriber Name: _____ DOB: _____

Subscriber ID: _____ Group: _____ SS#_____

Secondary Insurance: _____ Group: _____ DOB: _____

Emergency Contact Name/Phone #/Relationship

_____

Pharmacy Name: _____Mail Order Pharmacy Name: _____

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Fonticiella Medical Clinic for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service.

Signature of Responsible Party: _____ Date: _____

Responsible Party (if minor): _____ Date: _____

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party : _____Date: _____

Responsible Party (if minor): _____Date: _____