



Welcome to Carroll Health Group (CHG). Our goal is to provide you with the best possible healthcare. To help us meet all of your healthcare needs, please fill out this form completely, in ink. If you have any questions or need assistance, please do not hesitate to ask the staff for assistance.

Personal Information

Date _____

First Name _____ Middle _____ Last _____
Address _____ Apt. No. _____
City _____ State _____ Zip _____
Home Phone # _____ Work # _____ Cell # _____

Male Female Date of Birth _____ Social Security # _____
 Married Divorced Widowed Separated Single

In the event of an emergency, who should we contact? (We prefer more than one contact number.)

Name _____ Relationship _____ Home # _____
Work # _____ Cell # _____

Who is your PCP? _____ Which Pharmacy do you use? _____

Responsible Party

Who is responsible for the account? (If self please just write self on name line.)

Name _____ Relationship to patient _____
Date of Birth _____ Social Security # _____
Address _____ Apt. No. _____
City _____ State _____ Zip _____
Employer _____ Work # _____ Home # _____

Insurance Information

Primary Insurance

Name of Insured _____
Relationship to patient _____
Insured's birth date _____
Social Security # _____
Employer _____
Insurance Company _____
Policy # _____
Group # _____

Secondary Insurance

Name of Insured _____
Relationship to patient _____
Insured's birth date _____
Social Security # _____
Employer _____
Insurance Company _____
Policy # _____
Group # _____

Please tell us who referred you to our practice by checking one of the following:

Relative Friend Insurance Company Advertisement Physician (Please name) _____

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.

I agree to pay any costs incurred in collecting any unpaid balance due to CHG including collection fees, court costs, and or attorney fees.

I understand that payments for office visits are due at the time services are rendered unless prior arrangements have been made with CHG.

Additionally, I understand that I will be billed \$35.00 for any returned check presented to the office for payment. No show fee(s) of \$30.00 for primary care visits and \$40.00 specialty visits will be billed to me, not my insurance company, when applicable. And further, the office reserves the right not to accept future checks if any checks have been returned previously.

X _____
Signature of patient or responsible party of minor (Under Seal)

Date