Maryland Heights Family & Acute Care

Your Pharmacy & Zip Code ____________________

PLEASE PRINT CLEARLY & FILL OUT COMPLETELY

Last Name:____________________ First Name:____________ MI:________

Date of Birth:__________ Male/Female Martial Status________SSN#______________

Please circle appropriate choices:

Language: *English Spanish French Other:*____________

Race: *White Black or African American American Indian Alaska Native Asian Native Hawaiian Pacific Islander Other:*____________

Ethnicity: *Hispanic or Latino Not Hispanic or Latino*

Smoking: *Current every day smoker Current some day smoker Former smoker Never smoker Smoker, current status unknown Unknown, if ever smoked*

Address: ____________________________________

City____________________ State__________ Zip__________

Home Phone:____________Cell Phone:____________ Work Phone:__________

Email Address:____________________________________

Emergency Contact Name:____________________ Phone:______________

Insurance Company Name: ________________Policy/Member ID:____________

Name of policy holder:____________________________________

Address of policy holder:____________________________________

Date of Birth (policy holder):________________ SSN#______________

Employer of Policy Holder:____________________________________

Address of Employer:____________________________________

Do you have a second insurance policy? Y or N Name of Ins Company: ____________

Name of policy holder: ____________________________________

Address of policy holder: ____________________________________

Date of Birth (policy holder):________________ SSN# ______________

How did you hear about us? ____________________________________

YOU ARE RESPONSIBLE FOR THE BALANCE ON YOUR ACCOUNT EVEN IF YOU HAVE INSURANCE.

I agree to the release of my medical records to the insurance company named above so that claims may be paid and payment should go directly to Maryland Heights Family & Acute Care.

Signed: ________________________ Date: ________________

FOR DRUG AND ALCOHOL TESTING ONLY

I voluntarily authorize Maryland Heights & Acute Care and its employees to collect and have performed by a laboratory urine/breath/blood test to determine the presence of controlled substances/illegal narcotics/alcohol, according to federal regulations and company policy authorize release of this information to my employer or prospective employer, and to MRO.

Signed: ________________________ Date: ________________

We value our patients at Maryland Heights Family & Acute Care. Appointment times are valuable to us and to our patients, therefore when a patient does not show for their scheduled appointment, it takes away an opportunity for another patient. It is our policy to charge a $25 fee for a missed/canceled appointment when we are not given a 24 hour notice.

I have read and understand office policy regarding missed/canceled appointments.

Signed: ________________________ Date: ________________