Patient Information Form Date:

Last Name_____ First Name _____ MI_____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Social Security Number _____ Date of Birth _____

Sex: M F (circle one) Marital Status: S M D W (circle one)

Spouse's Name _____

Spouse's Social Security Number _____

Spouse's Date of Birth_____

PATIENT EMPLOYER INFORMATION

Current Status: Employed Retired Disabled Student Other (circle one)

Employer Name _____

Address _____

City_____ State _____ Zip Code _____

EMERGENCY CONTACT

Name Relationship Phone Number

_____

HEALTH CARE CONTACT INFORMATION

Primary Care Physician _____Phone_____

Referring Physician _____ Phone_____

Pharmacy Name _____ Phone_____

POLICY HOLDER INFORMATION (If other than patient)

Last Name_____ FirstName _____ MI _____

Address_____

City_____ State_____ Zip Code _____

Social Security Number _____ Date of Birth_____

North Central Indiana Medical Clinic, LLC.
112 S Main Street, Milford IN 46542
ncimedical.com

Phone: (574) 832-6246
Fax: (574) 832-2001

Home Phone _____ Work Phone _____

Cell Phone _____ Marital Status: S M D W (circle one)

Employer's Name _____

Address _____

City_____ State _____ Zip Code _____

INSURANCE INFORMATION

Primary Insurance Name _____

Identification Number _____

Group/Policy Number _____

Address _____ City _____

State _____ Zip Code_____ Phone Number _____

INSURANCE INFORMATION CONTINUED

Secondary Insurance Name _____

Identification Number _____

Group/Policy Number _____

Address _____ City _____

State _____ Zip Code _____ Phone Number _____

Authorization to Release Information

I hereby authorize North Central Indiana Medical Clinic, LLC to release all information acquired in the course of my examination and/or treatment to process insurance claims.

I understand and agree that I am responsible for the payment of any charges which are incurred for the services provided by North Central Indiana Medical Clinic, LLC. If I fail to pay any balance due in a timely fashion and it becomes necessary for North Central Indiana Medical Clinic, LLC to retain an attorney to assist in the collection of my account , I do hereby agree to be responsible for all reasonable attorneys' fees incurred by North Central Indiana Medical Clinic, LLC

All the information which I have provided is true and accurate. I agree to notify North Central Indiana Medical Clinic, LLC. of any changes in my health status or in any of the information listed herein.

Photocopies of this form shall be as valid as the original.

Patient Signature: _____ Date:_____

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