ASSOCIATES IN FAMILY PRACTICE
12210 Plum Orchard Drive, Suite 212
Silver Spring, Maryland 20904
301-622-6020

PLEASE PRINT CLEARLY

ADULT PATIENT'S NAME:_____
FIRST MIDDLE LAST

STREET ADDRESS:_____

CITY,STATE,ZIP:_____

GENDER: MALE FEMALE (CIRCLE ONE) DATE OF BIRTH:_____
HOME PHONE: _____ EMAIL ADDRESS: :_____
CELL PHONE:_____ WORK PHONE:_____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED OTHER

EMPLOYER:_____ OCCUPATION:_____

SPOUSE *OR* EMERGENCY CONTACT NAME:_____
ADDRESS:_____
HOME PHONE:_____ WORK/CELL PHONE:_____
DATE OF BIRTH:_____ RELATIONSHIP IF NOT SPOUSE:_____

ARE YOU ALLERGIC TO ANY MEDICATION?: YES NO (CIRCLE ONE)
MEDICATION NAME:_____

REFERRED BY:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ POLICY HOLDER:_____
ID NUMBER:_____ GROUP NUMBER:_____
POLICY HOLDER SSN:_____ POLICY HOLDER DOB:_____
POLICY HOLDER EMPLOYER:_____

SECONDARY INSURANCE:_____ POLICY HOLDER:_____
ID NUMBER:_____ GROUP NUMBER:_____
POLICY HOLDER SSN:_____ POLICY HOLDER DOB:_____
POLICY HOLDER EMPLOYER:_____

AUTHORIZATION

I, _____, hereby authorize Associates in Family Practice, P.A. (AIFP) to apply for benefits on my behalf for services rendered to me and request that payment be made by my insurance company and that my payments be sent directly to AIFP. I understand that it is the policy of AIFP to only bill my insurance company if they participate with that company, and if they do not, it will be my responsibility to submit the claim to my insurance company for reimbursement of my expenses. I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, and if my account is past due, it will be turned over to collections. I understand am responsible for reasonable attorney's fees and cost of collection in the event of default. Further, I understand that there is a $35.00 fee for returned checks.

I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any information relating to any claim or benefits, in order to process any claim for benefits. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this at any time in writing.

SIGNATURE OF PATIENT:_____ DATE:_____