Memorial Medical Group
a service of Comanche County Memorial Hospital

Patient Information

First Name	Last Name	MI

Date of Birth	SSN	Gender	Marital Status S M D W

Mailing Address	City	State	Zip

Home Phone	Cell phone	Work Phone

Email Address	Preferred Language

Race (Circle)	• Asian • Native American • Black or African American • White • Native Hawaiian • Other

Ethnicity (Circle)	Hispanic or Latin	Not Hispanic or Latin

Pharmacy Name	City	Phone #

Responsible Party (Only fill out employee information if same as above)

First Name	Last Name	MI	DOB

Phone	Email	Gender	SSN

Address

Relationship to Patient (Circle)	• Spouse • Parent • Child • Employee • Life Partner • Other

Employer Name	Address	Phone #

Insurance Information (Provide front desk with card/s)

Primary Insurance Name	ID number	Group Number	

Policy Holder Name	Policy Holder SSN	DOB	Relationship

Secondary Insurance Name	ID number	Group Number	

Policy Holder Name	Policy Holder SSN	DOB	Relationship

Emergency Contact

Name	Phone #	Relationship to patient

Patient Privacy

I have received a copy of Comanche County Memorial Hospital Notice of Privacy Practice	Please Initial:

Do you have an advanced Directive? (Circle)	Yes / No

I understand that I am responsible for the payment of services. Insurance will be filed as a courtesy; however, after 60 days if no response is received, I understand that I could be responsible for charges. I understand that I am responsible for payment of any amount that is not covered by insurance. I also authorize the release of any medical information necessary to process insurance claims for services rendered.

Patient/Reposible Party Signature	Date