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 (Select One)	☐ **Asian** ☐ **Native American** ☐ **Black or African American** ☐ **White** ☐ **Native Hawaiian** ☐ **Other**		
Ethnicity (Circle)	Hispanic or Latin	Not Hispanic or Latin	
Pharmacy Name and Address:	**City:**	**Phone #:**	
Primary Care Provider:		**Referring Provider:**	

Responsible Party (Complete if Not the Same as Above)

First Name:	**Last Name:**	**MI:**	**DOB:**
Phone:	**Email:**	**Gender:**	**SSN:**
Address:			
Relationship to Patient (Select One)	☐ **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/Responsible Party Signature:	**Date:**