Memorial Medical Group
a service of Comanche County Memorial Hospital

Patient Information

First Name:		**Last Name:**	
Date of Birth:	**SSN:**	**Gender at Birth: M or F**	**Marital Status:** S
		Gender Identity (optional):	
Mailing Address:		**City:**	**State:**
Home Phone:	**Cell phone:**	**Work Phone:**	
Email Address		**Preferred Language**	
Race (Select all that apply)	▫ Asian ▫ American Indian/Native American ▫ Alaskan Native	▫ Alaskan Native ▫ Black/African American	▫ Native Haw ▫ White/Cauca
Ethnicity (Select)	▫ Hispanic or Latino	▫ Not Hispanic or Latino	
Pharmacy Name and Address:		**City:**	**Phone #:**
Primary Care Provider:		**Referring Provider:**	
Employer Name	**Address**		**Phone #**

Responsible Party (Complete if Not the Same as Above)

First Name:	**Last Name:**	**MI:**	
Phone:	**Email:**	**Gender:**	**SSN:**
Address:			
Relationship to Patient (Select One)	▫ Spouse ▫ Parent ▫ Child ▫ Employee ▫ Life Partner		

Insurance Information (Provide Front Desk with card/s)

Primary Insurance Name:	**ID number:**	**Group Number:**
Policy Holder Name:	**Policy Holder SSN:**	**DOB:**
Secondary Insurance Name:	**ID Number:**	**Group Number:**
Policy Holder Name:	**Policy Holder SSN:**	**DOB:**

Emergency Contact

Name:	**Phone #:**	**Relationship to patient:**

MI:

M D W

Zip:

vaiian
sian

DOB:

▫ Other

Relationship:

Relationship:

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, response is received, I understand that I could be responsible for charges. I understand that I am responsible f amount that is not covered by insurance. I also authorize the release of any medical information necessary to p claims for services rendered.		
Patient/Responsible Party Signature:		**Date:**

after 60 days if no for payment of any process insurance