The Family Doctor

151 Rams Plaza, 1728 Fordham Blvd, Chapel Hill, NC 27514 (919) 968-1985 Fax (919) 942-0038

PLEASE PRINT

DATE:_________________________ CHART #_________________________

Patient's Last Name_________________________________ First_________________________________ MI_____

Date Of Birth: ____/____/____ Age:______ Social Security#:_______-______-________ Sex_____ Marital Status_____

Address:____

City____State_______________ Zip____________________

Home Phone:(_____)_______-__________ Cell Phone: (_____) ________-_____________

Work Name:____Work Phone: (_____)______-__________ X__________

Work Address:____

Emergency Contact: ___________________________ Relationship:______________Telephone (_____) _____-_________

IF YOU ARE FROM OUT OF TOWN:

Local Phone: (_______) ________-_________________When will you be leaving this area?_________________________

INSURED / RESPONSIBLE PARTY:

Last Name:_______________________First___________________MI_____ Relationship To Patient__________________

Insured Address:____

Street City State Zip

Insured Phone: (_____)______-_________ Insured Birthdate:_____/______/______ Insured SS#:_______-______-_______

Insured Employer:____ Work Phone: (______)________-_________

METHOD OF PAYMENT: (Please Check)

☐ CASH ☐ PERSONAL CHECK – *We verify with Telecheck* ☐ CREDIT CARD (Discover, MasterCard, Visa)

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE

UNLESS YOU ARE A MEMBER OF ONE OF THE HEALTH MAINTENANCE ORGANIZATIONS LISTED BELOW.
If the HMO/PPO is your secondary coverage, or if you belong to a plan with a deductible, payment is due at the time of service.
If covered by Commercial Insurance, we will be happy to prepare claim forms for you to submit for reimbursement.

•Aetna HMO/PPO •BCBS– PCP/MedPt •BCBS – Care/Choice •BCBS - PPO/PCS •Cigna HMO / PPO
•Med Cost PPO •Medicare RR – Assignment NOT accepted with Medicare; full payment due at time of service
•ONE Health PPO/POS •PHCS PPO/POS •United Health Plan •Well Path
•Workers Compensation – with company account & employer approval

I authorize any holder of medical information about me to release to
my insurance company and to the Centers for Medicare and Medicaid Services and its agents
any information needed to determine these benefits or the benefits related to the services.

Signature (required):____ Date:_______________

HOW DID YOU LEARN ABOUT THE FAMILY DOCTOR? (Please Check ONE):

☐ Yellow Pages (1) ☐ Family/Friend (2) ☐ Employer (3) ☐ Family Doctor Sign (4)
☐ Professional Referral (5) ☐ Family Doctor Brochure (6) ☐ Carolina Parent (7) ☐ Sports Camp (8)
☐ School (9) ☐ Website (11) ☐ Other (10) ☐ Unknown (99)
☐ Apartment Complex (12) ☐ Hotel / Motel (13)