

Med Center 1
1688 East Arlington Blvd.
Greenville, NC 27858
(252) 353-1464

Name: _____ Phone# _____
 Last First MI

Street Address: _____

Mailing Address _____

City _____ **St** _____ **Zip:** _____ - _____ **Sex:** (circle one) M/F

Birth date: _____ **SS#** _____ **Drivers License #** _____

Email: _____

Marital Status (circle one) S M SEP DIV WID

Employment Status (circle one) F/T P/T Retired Unemployed Self Employed

Student Status (circle one) F/T P/T Non

Patient Employer _____ **Phone#** _____

Spouse's Name _____ **Spouse's DOB** _____

Spouse SS# _____ **Spouse's Phone#** _____

Ins Plan Name _____

Policy Holder

Name _____ **DOB** _____ **SS#** _____

Emergency contact name and number _____

I, the Patient, Parent or Guardian of a minor under 18, certify that the insurance information is correct. I hereby authorize Med Center 1 to release all necessary information to secure payment of benefits. I authorize the use of my signature on all insurance submissions. I am also aware that I am responsible for all charges not covered by my insurance.

We do not accept Medicare assignment therefore you are responsible for your charges. As a courtesy we will file your charges to Medicare so reimbursement will go to you.

Method of payment (circle) Cash Credit Card Check Insurance Employer

Signature: _____ **Date:** _____