Adult Medicine Clinic of Blytheville, P.C.

Last Name _____ Date of Birth _____
First Name _____ MI _____ Male _____ Female _____
Address _____ Marital Status _____
_____ Social Security # _____
City _____ Employer Name _____
State & Zip _____ Employment Status (FT,PT, retired) _____
Home Phone _____ Spouse Name _____
Cell Phone _____ Spouse Cell Number _____
Work Extension Spouse Work Number

Responsible Party

Last Name _____
First Name _____
Middle Initial _____
DOB _____
Social Security # _____
_____ Male _____ Female
Phone _____
Relation

Emergency Contact: (NOT A SPOUSE)

Last Name _____
First Name _____
Relation _____
Address _____
City _____
State & Zip _____
Home Phone _____
Work Phone

Insurance (NEED COPY OF CARDS)

Primary Insurance _____
Insurance Address _____
City _____
State & Zip _____
Phone
Subscriber # _____
Co-pay amount _____
Insured Name _____
Relationship _____
Group Number

Secondary Insurance _____
Insurance Address _____
City _____
State & Zip _____
Phone _____
Subscriber # _____
Co-pay amount _____
Insured Name _____
Relationship _____
Group Number

Additional Information

Email address: _____
May we notify you of appointments at this address? _____ Yes _____ No
Name of Pharmacy _____ Pharmacy Phone Number _____
Mail order Pharmacy _____ Mail order ID Number _____
Mail order fax number _____
How did you hear about us?

Assignment of Benefits and Release of Related Medical Records

I hereby assign, transfer and set over to Dr. Shalender Mittal, or Adult Medicine Clinic of Blytheville all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I understand that I am financially responsible for all charges whether or not covered by insurance. I authorize any holder of medical information about me to be released to my insurance company and its agents, and information needed to determine these benefits or the benefit of payable services. This authorization shall remain valid until written notice is given by me revoking said authorization.

Signature _____**Date** _____