CARROLL HEALTH GROUP
A LifeBridge Health Partner

Welcome to Carroll Health Group (CHG). Our goal is to provide you with the best possible healthcare. To help us meet all of your healthcare needs, please fill out this form completely, in ink. If you have any questions or need assistance, please do not hesitate to ask the staff for assistance.

Personal Information

Date _____

First Name _____ Middle _____ Last _____

Address _____ Apt. No. _____

City _____ State _____ Zip _____

Home Phone # _____ Work # _____ Cell # _____

Patient Email: _____

☐ Male ☐ Female Date of Birth _____ Social Security # _____

☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single

In the event of an emergency, who should we contact? (We prefer more than one contact number.)

Name _____ Relationship _____ Home # _____

Work # _____ Cell # _____

Who is your PCP? _____ Which Pharmacy do you use? _____

Responsible Party

Who is responsible for the account? (If self please just write self on name line.)

Name _____ Relationship to patient _____

Date of Birth _____ Social Security # _____

Address _____ Apt. No. _____

City _____ State _____ Zip _____

Employer _____ Work # _____ Home # _____

Insurance Information

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birth date _____

Social Security # _____

Employer _____

Insurance Company _____

Policy # _____

Group # _____

Secondary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birth date _____

Social Security # _____

Employer _____

Insurance Company _____

Policy # _____

Group # _____

Please tell us who referred you to our practice by checking one of the following:

☐ Relative ☐ Friend ☐ Insurance Company ☐ Advertisement ☐ Physician (Please name) _____

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.

I agree to pay any costs incurred in collecting any unpaid balance due to CHG including collection fees, court costs, and or attorney fees.

I understand that payments for office visits are due at the time services are rendered unless prior arrangements have been made with CHG. Additionally, I understand that I will be billed $35.00 for any returned check presented to the office for payment. No show fee(s) of $30.00 for primary care visits and $40.00 specialty visits will be billed to me, not my insurance company, when applicable. And further, the office reserves the right not to accept future checks if any checks have been returned previously.

X _____ _____

Signature of patient or responsible party of minor (Under Seal) Date