

# Cary Medical Clinic, PC

550 New Waverly Place, Suite #105  
Cary, NC 27518

Tel 919 233 2022

Fax 919 233 2212

(PLEASE PRINT CLEARLY)

## Patient Information

Name \_\_\_\_\_ Home Phone # \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ Cell Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Soc Sec # \_\_\_\_\_ Email address \_\_\_\_\_

Sex M F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Single Married Widowed Separated Divorced

Employers Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Parent, Spouse, or Partner Full Name \_\_\_\_\_

Employers Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Who may we thank for referring you ? \_\_\_\_\_

In case of emergency who should be notified \_\_\_\_\_ Phone \_\_\_\_\_

## Primary Insurance

Insurance Company \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Please Fill-out **ALL INFORMATION** if policy holder is other than Self

Policy Holder Name \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M F Soc. Sec.# \_\_\_\_\_

## Secondary Insurance

Insurance Company \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_  
Last Name First Name Middle Initial

## Allergy Alert

Are you allergic to any medicine? YES  NO  Don't Know

If yes, write the medication here \_\_\_\_\_

### FINIANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I understand that Cary Medical Clinic will make all attempts possible to collect from my current insurance carrier as long as correct insurance card(s) are presented BEFORE treatment. After 120 days, I may receive a bill if my insurance does not respond.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize for Cary Medical Clinic to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers or other involved in processing and collecting of claims in accordance with the HIPPA Patient Confidentiality Act of 1996.

Signature \_\_\_\_\_ Date \_\_\_\_\_

THANK YOU FOR BEING A PATIENT AT CARY MEDICAL CLINIC.

CHART # \_\_\_\_\_