FENTON MEDICAL CENTER
NEW PATIENT **ADULT** FACE SHEET

DATE:	PATIENT NAME:	DOB:
OCCUPATION:	SEX: M F	MARITAL STATUS: S M D W
ADDRESS:		HOME #:
CITY:	STATE: ZIP CODE:	EMAIL:
SS#:	EMPLOYER:	EMPLOYER PHONE #:
INSURANCE:	CARDHOLDER'S FULL NAME:	
MEDICARE:	MEDICAID:	
GROUP #:	CONTRACT #:	CO-PAY:
NAME OF SECONDARY INSURANCE:	CARDHOLDER'S FULL NAME & RELATIONSHIP:	

SPOUSE INFORMATION-

NAME: ____________________

DOB: ____________________

SS#: ____________________

OCCUPATION: ____________________

EMPLOYER: ____________________

EMPLOYER PHONE #: ____________________

INSURANCE: ____________________

GROUP #: ____________________

CONTRACT #: ____________________

CO-PAY: ____________________

EMERGENCY INFORMATION-

03/21/2017

CONTACT PERSON:
(OUTSIDE HOUSEHOLD) ______________________________

RELATIONSHIP: ______________________________

TELEPHONE #: ______________________________

PLEASE READ AND SIGN BELOW: I acknowledge that all the information given is correct. I accept responsibility for any charges incurred by myself or a family member while on my account. I am aware that fees for services are expected at time of service and that a monthly re-bill fee of $5.00 is charged on unpaid accounts.

Signature: ______________________________ Date: ______________________________