



**Patient Information:**

**Account Number:** \_\_\_\_\_

Full Legal Name: \_\_\_\_\_  
(First Name) (M.I.) (Last Name)

Birthdate: M \_\_\_ / \_\_\_ / \_\_\_ Race: \_\_\_\_\_ Ethnicity \_\_\_\_\_  
Month Date Year

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: M / F (Circle)

Mailing Address: \_\_\_\_\_

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

Home Number: (\_\_\_\_) \_\_\_\_\_ Cell Number: (\_\_\_\_) \_\_\_\_\_ Preferred Language: \_\_\_\_\_

**Best Message Number:** (\_\_\_\_) \_\_\_\_\_ **May we leave a message? Y/N (Circle)**

**Email Address:** \_\_\_\_\_ @ \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Number: (\_\_\_\_) \_\_\_\_\_

Local Accommodation if Visiting – Hotel or Condo Name: \_\_\_\_\_ Number: (\_\_\_\_) \_\_\_\_\_

**Guarantor: (if different from patient information)**

Full Legal Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
(First Name) (M.I.) (Last Name)

Mailing Address: \_\_\_\_\_

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

Home: (\_\_\_\_) \_\_\_\_\_ Cell Number: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Birthdate: \_\_\_ / \_\_\_ / \_\_\_ Sex: M/F (Circle) Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Date Year

**Insurance Information:**

(Complete only if CMM is contracted with your insurance company. A list of contracted insurance companies is posted at the front desk)

Insurance Company Name: \_\_\_\_\_ PPO Network: \_\_\_\_\_

Insurance Billing Address \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Insurance Phone #: (\_\_\_\_) \_\_\_\_\_

Policy/ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Subscriber Information:**

Subscriber Name: \_\_\_\_\_  
(First Name) (M.I.) (Last Name)

Subscriber Telephone Number: (\_\_\_\_) \_\_\_\_\_ Subscriber Address: \_\_\_\_\_

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

Subscriber Birthdate: \_\_\_ / \_\_\_ / \_\_\_ Subscriber Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Date Year

Relationship to Insured: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

**Financial Policy:** By signing below, I agree to the following:

1. that I have the authority to authorize CMM to treat the patient.
2. that CMM has the authority to obtain any medical records information needed to treat patient.
3. that CMM may release any and all medical records to secure payment for service rendered.
4. that the responsible party will make immediate payment for services rendered: if CMM is contracted with your insurance company, payment is due immediately on co-pays, non-covered services and co-insurance, and after twenty days on balances due after claim is processed.
5. that if the account becomes past due, a service charge not to exceed 18% per month may be applied.
6. that failure to cancel a scheduled appointment may result in a cancellation fee.
7. occasionally, a charge may be overlooked and added to your account at a later date. You and your insurance company will be held responsible for missed charges.
8. it is my responsibility to know the patient's insurance plan and covered benefits.
9. that I consent to the procedures, which may be performed during the office visit.
10. I authorize payment of medical benefits to CMM for services rendered. I also understand that I am financially responsible to CMM for charges not covered by my insurance carrier.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Name: \_\_\_\_\_