Family Care Assoc., LLC.

Patient or Guardian Signature:

	ate First Name			Last Name		MI	Gender	
Data of Divide	A = 0					N.4 - w	tal Ctatus	
Date of Birth	Age	Social Security # (Last 4 Digits)		Occupation		Marital Status		
Street Address				City, State		Zip Code		
			I					
Cell Phone #			Home Phone #		Work Phone #		#	
			L Emai	l Address				
EMERGEN	CY CON							
Name:				Re	Relation to Patient			
Home Phone #			C	ell Phone #	W	Work Phone #		
PHARMAC			T					
Name:			M	Nain Phone #		Location #		
INSURANO	'E INFO	RMATION						
THE CHAIN	<u>L IIII O</u>	KMIIION						
	1.0			CE CARD & PHOTO ID	11.	C1 · .1		
If your insurance coverage is under another personantely Mame of Policy Holder				son's name, please note thei	Date of Birth			
			.,					
RESPONSI	BLE PA	RTY						
	L	_ast Name		First Name		MI	Gender	
Date of Birth Age Social Security #		(Last 4 Digits)	Occupation		Marital Status			
2 4 6 6 7 2 11 6 11	7.80	occiai occiai ici iii	(1000 1 1 18:00)	Companion				
Street Address				City, State		Zip Code		
Cell Phone #			Нс	ome Phone #	Work Phone #			
						WOTK THORE II		
			Emai	l Address				
21		ne nottom:		to Middletown Family Care Assoc	LLC and its emplo	vees. agents.	and medical	
			ereby give permission					
Authorizeroviders to releas	ation and Ass e medical info	ignment of Benefits: I he rmation to health plans,	health organizations,	governmental agencies, and other	_	-		
Authoria providers to releas payment of medica	eation and Ass e medical info	ignment of Benefits: I he rmation to health plans, dered to me. I hereby aut	health organizations, thorize payment of th	governmental agencies, and other e medical benefits otherwise paya	ble to me to be dire	ected to Mid	dletown Famil	
Authorizeroviders to release bayment of medical Care Assoc., LLC. I	eation and Ass e medical info al services reno consent to hav	ignment of Benefits: I he rmation to health plans, dered to me. I hereby aut re any monies received b	health organizations, thorize payment of th y the provider of serv	governmental agencies, and other e medical benefits otherwise paya ices on my behalf to be applied to	ble to me to be dire	ected to Mide counts. I assu	dletown Famil ıme full	
Authoriz providers to releas payment of medica Care Assoc., LLC. I responsibility for p	eation and Ass e medical info al services rend consent to hav ayment of any	ignment of Benefits: I he rmation to health plans, dered to me. I hereby aut re any monies received by charges for the medical	health organizations, thorize payment of th y the provider of serv services provided. I u	governmental agencies, and other e medical benefits otherwise paya	ble to me to be dire my outstanding acc edical information n	ected to Mide counts. I assu nay be electr	dletown Famil Ime full onically	
Authorizeroviders to release ayment of medical are Assoc., LLC. I desponsibility for pubmitted to any of the control of the co	eation and Ass e medical informal al services reno consent to have ayment of any r all treating p	ignment of Benefits: I he rmation to health plans, dered to me. I hereby aut we any monies received by charges for the medical providers, hospitals, and/o owledgement: I hereby a	health organizations, thorize payment of th y the provider of serv services provided. I u or health care entities cknowledge that I ha	governmental agencies, and other e medical benefits otherwise paya ices on my behalf to be applied to nderstand that any or all of my me s. I permit a copy of this authorizat we received and reviewed the FIN	able to me to be dire my outstanding acc edical information n tion to be used in pl ANCIAL POLICY of N	ected to Mid counts. I assu nay be electr ace of the or Middletown F	dletown Famil ime full onically iginal. amily Care Ass	
providers to releas payment of medica Care Assoc., LLC. I responsibility for p submitted to any c	eation and Ass e medical informal al services reno consent to have ayment of any r all treating p	ignment of Benefits: I he rmation to health plans, dered to me. I hereby aut we any monies received by charges for the medical providers, hospitals, and/o owledgement: I hereby a	health organizations, thorize payment of th y the provider of serv services provided. I u or health care entities cknowledge that I ha	governmental agencies, and other e medical benefits otherwise paya ices on my behalf to be applied to nderstand that any or all of my me i. I permit a copy of this authorizat	able to me to be dire my outstanding acc edical information n tion to be used in pl ANCIAL POLICY of N	ected to Mid counts. I assu nay be electr ace of the or Middletown F	dletown Famili Ime full onically iginal. amily Care Ass	

Relationship:



Date: