Monarch
MEDICAL GROUP

Patient Information

Legal Name_____
First MI Last

Sex: M F DOB_____

Preferred language_____

SS #_____

Physical Address_____

City_____ State_____ Zip_____

Mailing Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell_____

email address _____

Preferred Pharmacy _____

Marital Status (Please circle one): S M W D

Race (please circle one): American Indian or Alaskan Native Asian White

Black or African American Hispanic Native Hawaiian or other Pacific Islander

Other Race Other Pacific Islander Unreported/refuse to report

Ethnicity (Please circle one): Hispanic or Latino

Not Hispanic or Latino Refuse to report

Employer_____

Patient Occupation_____

Employer Address_____

City_____ State_____ Zip_____

Employer Phone_____

If Patient is a Minor

Mother's Legal Name_____
First MI Last

Physical Address_____

Mailing Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell_____

Employer_____

Employer Phone_____

SS #_____ DOB_____

Father's Legal Name_____
First MI Last

Physical Address_____

Mailing Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell_____

Employer_____

Employer Phone_____

SS#_____ DOB_____

Spouse

Name_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell_____

Emergency Contact

Name_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell_____

Relationship to Patient_____

Primary Insurance

Primary Insurance_____

Policy ID#_____ Group#_____

Subscriber Name_____ Relationship to Patient_____
First MI Last

Subscriber Address_____ City_____ State_____ Zip_____

Phone_____

Subscriber SS#_____ Subscriber DOB_____

Secondary Insurance

Insurance Name_____

Policy ID#_____ Group#_____

Subscriber Name_____ Relationship to Patient_____
First MI Last

Subscriber Address_____ City_____ State_____ Zip_____

Phone_____

Subscriber SS#_____ Subscriber DOB_____

I understand that the policy of Monarch Medical Group is; payment in full is required at the time of services for each visit for all patients who have not met their deductible or do not have insurance coverage, and that any and all payments are also required at the time of services.

I understand that I am financially responsible for the payment of medical charges incurred on my behalf at Monarch Medical Group, regardless of the third party/insurance coverage.

I consent to and authorize that Monarch Medical Group may furnish medical information to any third party who may be responsible for payment of all or part of my charges incurred at Monarch Medical Group. I authorize my insurance company, or any responsible third party to pay benefits directly to Monarch Medical Group.

I understand that if Monarch Medical Group needs to send me to a specialist for care beyond his practice that records will need to be sent on my behalf in order for the specialist to treat me accordingly. Monarch Medical Group will send over any pertinent information including office notes, labs, x-rays, medication lists, allergy lists, hospital records, ect.

By signing I verify that all the information I have filled out is correct to the best of my knowledge and that I have read and agree to comply with the above policies and information.

Signature of Patient_____ Date_____

Signature of Parent/Legal Guardian (if minor)_____ Date_____

Do you have advance directives in place (eg., living will, durable power of attorney etc.)? Yes No
If No, would you like information about advanced directives? Yes No
If Yes, which kind (pleases circle one): Living Will Physician Orders for Life Sustaining Treatment (POLST)

Durable power of attorney Health Proxy DNR

Full Code