CHART #___________

NAME____
ADDRESS____________________________ DATE OF BIRTH__________
CITY________________________________ STATE_____ ZIP__________
E MAIL ADDRESS____
SINGLE____ MARRIED___DIVORCED___WIDOWED___PARTNER______
ETHNICITY/RACE____
LANGUAGE_________________SECONDARY_________________________
PHONE#______________________________ EMPLOYED Y___ N___
EMPLOYER NAME________________________ WORK # ________________
EMERGENCY CONTACT NAME & NUMBER__________________________
PRIMARY CARE PHYSICIAN____

I hereby assign all medical benefits including Medicare, Private Insurance and other Health plans to Nancy L. Thornton MD, PA. I understand that I am financially responsible for all charges whether or not paid by my insurance for services rendered.
I authorize the release of any medical information necessary to process my medical claim(s).

I give your practice permission to communicate test results by leaving a message on my voice mail, answering machine or cell phone.

____________________________ ___________
Patient signature Date

PRACTICE POLICY **INITIAL BELOW**

I UNDERSTAND THAT THE FOLLOWING FEES ARE MY RESPONSIBILITY AND I WILL INITIAL AS ACKNOWLEDGEMENT:

$35.00 FOR NO SHOW FEE____________
$50.00 FOR RETURNED CHECK FEE____________
$35.00 FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS NOTICE______