BrownClinic P.L.L.P.
Personal Care From The People You Know And Trust.

Patient Information

Name First ______________________ Middle ______________________ Last ______________________

Patient Email ______________________ Legal Guardian (if patient is a minor) ______________________

Address ______________________ City ______________ State ____________ Zip __________

Phone No. home ______________________ mobile ______________________ work ______________________

SS No. ______________________ Patient/Guardian Employer & Ph. No. ______________________

Spouse ______________________ Spouse's Employer & Ph. No. ______________________

OUTSIDE HOUSEHOLD, WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?

Name ______________________ Relationship to patient ______________________

Address ______________________ City ______________ State ____________ Zip __________

Phone No. home ______________________ mobile ______________________ work ______________________

Information concerning your care will be forwarded to your referring Doctor unless otherwise specified below.

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How do you want to be contacted by your doctor? ______________________

Who else is authorized to speak with about your care and account? ______________________

Name ______________________ Phone No. ______________________

PLEASE PRESENT YOUR INSURANCE CARD & DRIVERS LICENSE TO RECEPTIONIST

Primary Insurance Company Name ______________________

Address ______________________ City ______________ State ____________ Zip __________

Group No. / Name ______________________ Policy No. ______________________

Phone ______________________ Insured Name & DOB ______________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Company Name ______________________

Address ______________________ City ______________ State ____________ Zip __________

Group No. / Name ______________________ Policy No. ______________________

Phone ______________________ Insured Name & DOB ______________________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Who is financially responsible for the account? ______________________

Name ______________________ DOB ______________ Phone No. ______________________

Please remember that some insurance pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to. This assignment will remain in effect until revoked by me in writing. A photocopy of this assessment shall be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize assignee to release all information necessary to secure the payment.

Please Sign ______________________________________ Date ______________________