# CODDINGTON MEDICAL FAMILY PRACTICE, LLC

## PATIENT INFORMATION

| | |
|---|---|
| Reason for Visit: | Date: |
| Name: | Date of Birth: |
| Address One: | Social Security #: |
| Address Two: | Sex: |
| City: | Employer: |
| State: Zip: | Address: |
| Home Phone #: | Emergency Contact: |
| Work Phone #: | Emergency Phone #: |
| Cell Phone #: | Emergency Relationship: |
| Marital Status: S ☐ M ☐ D ☐ W ☐ | If other than patient: |

## GUARANTOR INFORMATION

| | |
|---|---|
| Name: | Date of Birth: |
| Address One: | Social Security #: |
| Address Two: | |
| City: | Employer: |
| State: Zip: | Employer Address: |
| Home Phone #: | Employer City: |
| Work Phone #: | Employer State: Zip: |
| Cell Phone #: | |

_____ _____

**Signed (patient or parent/guardian) if minor)** **Date**

# CODDINGTON MEDICAL FAMILY PRACTICE, LLC

**Authorization to Pay Benefits to Physician:** I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Coddington Medical Family Practice, LLC, when he accepts assignment.

_____ _____

**Signed (patient or parent/guardian) if minor)** **Date**