CODDINGTON MEDICAL FAMILY PRACTICE, LLC

PATIENT INFORMATION

Reason for Visit:	Date:
Name:	Date of Birth:
Address One:	Social Security #:
Address Two:	Sex: M ☐ F ☐
City:	**Email:**
State: Zip:	Employer:
Home Phone #:	Address:
Work Phone #:	Emergency Contact:
Cell Phone #:	Emergency Phone #:
Marital Status: S ☐ M ☐ D ☐ W ☐	Emergency Relationship:

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 #:	

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.

Authorization to Release Medical Information: I hereby authorize my Provider, Coddington Medical Family Practice, LLC, to release any information necessary for my course of treatment.

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