

MIDDLETOWN FAMILYCARE ASSOC.

Ketlay Professional Plaza

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PATIENT INFORMATION

Name: (First, M.I. Last) _____ Sex: Male / Female
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security# _____
Home Phone: _____ Work Phone: _____ Marital Status: S M W D
Employer Name: _____ Employer Address: _____
Emergency Contact Name: _____ Phone: _____
DRUG ALLERGIES: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ ID# _____ Group _____
Insured's Name: _____ Relationship to patient: Self / Spouse / Child / Dependant
Insured's Social Security # _____ Insured's D.O.B. _____ Employer: _____
Date Insurance was effective: _____ Phone: _____
2nd Insurance Company: _____ ID# _____ Group _____
Insured's Name: _____ Relationship to patient: Self / Spouse / Dependant
Insured's Social Security # _____ Insured's D.O.B. _____ Employer: _____
Date Insurance was effective: _____ Phone: _____

RESPONSIBLE PARTY IF NO INSURANCE

Name of Insured: (First, M.I. Last) _____ Sex: Male / Female
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security# _____ Marital Status: S M W D
Home Phone: _____ Work Phone: _____
Employer Name: _____ Employer Address: _____

❖ Please take a moment to tell us how you heard about this office? _____

I hereby assign, transfer, and set over to Middletown Familycare Assoc. L.L.C. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I hereby authorize Middletown Familycare Assoc. L.L.C. and its providers to perform random urine drug test screenings if medically indicated.

Patient's / Parent Signature

Date