NORTH STONINGTON
MEDICAL WALK-IN CENTER
82 Norwich-Westerly Rd. (Rt 2)
North Stonington, CT 06359

Patient Information

Name:_______________________________________SS#________________________
Patient Address:____
City:______________________________ State:________Zip Code: _______________
Patient Sex:_____ DOB:_____ Home Phone:_____________ Cell #________________
Preferred Pharmacy/Town the pharmacy is in:
____

Primary Insurance

Person Responsible for Account:____
Relationship to Patient:_______________________________ DOB:________________
Address:____
Home Phone:_____________________________________SS#:____________________
Employed by:______________________________ Work Phone:____________________
Business Address:____
Occupation:___________________________ Insurance Company:_________________
Group #_______________________________ Subscriber #_______________________

IS PATIENT COVERD BY ADDITIONAL SERVICE? Yes________ No________

Secondary Insurance

Person Responsible for Account:____
Relationship to Patient:_______________________________ DOB:________________
Address:____
Home Phone:_____________________________________SS#:____________________
Employed by:______________________________ Work Phone:____________________
Business Address:____
Occupation:___________________________ Insurance Company:_________________
Group #_______________________________ Subscriber #_______________________

I authorize, North Stonington Medical Walk-In Center, P.C., to administer medical care and medications that are deemed advisable or necessary in the execution of my or my dependant's treatment. By my signature I also acknowledge that no guarantees have been made to me as to the favorable outcome of any procedures or treatments.

I, the undersigned certify that I or (my dependants) have insurance with ____________________________ and assign insurance benefits directly to North Stonington Medical Walk-In Center, P.C... I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the release of all information necessary to process any claims. I authorize the use of this signature on all submissions. I also request payment of government benefits to be made to either myself or to the party who accepts assignment.

________________________________ ____________________________ ________________
Patient or Relationship Date
Responsible Party if under 18 yrs of age.