Ted J. Nifong, MD Lexi Fulk, MD Julie Bain, PA-C

Cedar Creek Family Medicine
5350 S. Main St.
Winston Salem, NC 27107
Phone: (336) 784-0505
Fax: (336) 784-5031

Patient: _____
Last Name First Name Initial

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work#: _____ Cell #: _____

Sex: M F Age: _____ Date of Birth: _____ SS#: _____

Email Address: _____ Pharmacy: _____

In case of **emergency**, who should we notify?_____ Phone#: _____

Patient Employer: _____

Employer's Address: _____

Person Responsible for Minor: _____ Phone: _____

Insurance: N Y If yes, please give a copy to the receptionist so a copy may be made for your file.

Insured's - Name: _____ DOB: _____
(This is the name of the person who carries insurance on the patient, if different than above.)

SS#: _____ Employer: _____
(This information is required in order for the insurance company to process the claim.)

Circle which applies: **Preferred Language:** English Spanish Other

Ethnicity: African American American Indian Asian European/Caucasian Latino/Hispanic Other_____

Race: Asian American Indian/Alaska Native African American/Black Caucasian/White Hispanic

More than 1 Race Native Hawaiian Other Pacific Islander Other_____

Assignment and Release

I, the undersigned, have insurance coverage with _____ and assign directly to Cedar Creek Family Medicine all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all my insurance submissions.

_____ _____
Signature of Insured / Guardian Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Cedar Creek Family Medicine for any services furnished me by that facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date