



HEALTH MANAGEMENT CONSULTANTS II, P.C. DBA

# Redi Care South

Patient Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Sex: Male/Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Patients Social Security #: \_\_\_\_\_ Responsible Party: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Name & Phone #: \_\_\_\_\_

I request that payment of authorized Medicare/other insurance carrier benefits be made on my behalf to Redi Care South for any services furnished to me by this provider. I authorize any holder of medical or other information about me to release to my insurance carrier and its agents any information needed to determine these benefits for related services. I am responsible for the total bill; regardless of the amount my insurance carrier pays.

Patient signature or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

## OFFICE USE ONLY

1<sup>st</sup> Insurance Carrier: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

2<sup>nd</sup> Insurance Carrier: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_