



ROYAL MEDICAL GROUP, PLLC
"Personalized Care for Optimal Health"

PATIENT INFORMATION

Name: _____

Date of Birth: ____ / ____ / ____ Sex: Male/Female

SSN: ____ - ____ - ____ Ht: ____ Wt: ____

Address: _____

City: _____ St: ____ Zip: _____

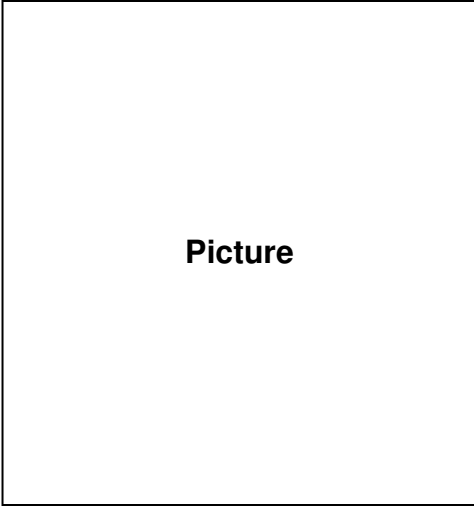
Phone: Home () _____ Cell () _____

Fax: () _____ Email: _____

Occupation: _____

Employer: _____ Phone: () _____

Street: _____ City: _____ St: ____ Zip: _____



Credit Card Information

Credit Cardholder Name: _____ Card Number: _____

Card Type: _____ Exp Date: _____ Security Code: _____

Insurance information

(Attach copy of front and back of insurance and/or Medicare card)

Primary Insurance: _____ Insured/Medicare ID #: _____ Group ID#: _____

Insurance Address: _____

City: _____ St: ____ Zip: _____ Telephone: () _____

Billing Information

(If different than above)

Address: _____

City: _____ St: ____ Zip: _____ Telephone: () _____

I certify that I am the patient, or duly authorized general agent of the patient, and have completed this form fully and completely. I give permission for my/the patient's picture to be taken and stored with the medical record. I understand that **PAYMENT IS DUE WHEN SERVICES ARE RENDERED** and even though I may have insurance coverage, I am personally responsible for the payment for all services in full. Returned checks are subject to a \$30 service fee. In the event that checks for payment are either insufficient or fraudulently written, or that unpaid debt must be pursued, I will also be responsible for any legal, banking, interest, and/or collection fees that may be incurred during any collection process.

(Patient or Agent's Signature)

(Date)