First Choice Medical Group, PC

921 East Broad Avenue
Rockingham, NC 28379
910-895-6042 (Phone)
910-895-3199 (Fax)

102 W. 32nd St
Lumberton, NC 28358
910-738-7710(Phone)
910-738-7749(Fax)

Larry E. Stogner, DC *** A. Shane Dreher, DC ***Thomas Forrest, DC
Wendell Wells, MD***Cynthia W. McLemore, MD
Sharon Knotts, APRN BC***Denene P. Smith, FNP
Donna Anderson, LMT

Personal Information

Patient Name: ____
(First) (Middle) (Last)

Address (Physical/PO BOX) ______________________________________

City: ____________________ **State:** ______________ **Zip:** ____________

Phone (Home) ______________________ **(Cell)** ________________________

E Mail Address: ____

Social Security # ______________________ **Date of Birth** __________________

Employer: ________________________ **Work #** ______________________

(Circle One) Marital Status-Single/Married/Divorced/Widowed **Sex: Male/Female**

Spouse Name: ____________________ **Spouse Contact #** __________________

How did you hear about our office? ____________________________________

If this patient is a minor, who gives permission for this child to be treated here at First Choice Medical Group, PC?

______________________________ **Relationship to Patient** ______________

In case of an emergency, list a person or persons who would be able to be contacted on your behalf.

Name ______________________________ **Contact #** ________________

Name ______________________________ **Contact #** ________________

Due to HIPPA practices, we ask what person or persons may have access to your medical information, pick up prescriptions, or ask any questions pertaining to you or your health history.

I hereby authorize my insurance to pay First Choice Medical Group, PC benefits due me under the terms of my policy of insurance issued by your company. Please send such benefits to 921 E. Broad Ave., Rockingham, NC 28379. Payment is authorized upon your receipt of the itemized statement for services rendered to me. Your policy was in full force and effect at the time services were rendered. Payment of such amounts to the above provider in whole or part shall constitute payment as if said payment were made directly to me. My signature also gives rights to the facility to release any and all information to any insurance company, attorney and/or adjuster as deem necessary to determine payable benefits on my account. I understand fully and agree that I am personally responsible for the total amounts due First Choice Medical Group, PC for any services rendered. If the bill remains unpaid and no satisfactory arrangements have been made and executed on it, the account will be reported to our legal department for further collections.

Patient Signature: ______________________________ **Date:** ____________