

The Medical Care Group, LTD.

Dr. Erik Johnson

Dr. Jennifer Lynch

**Please Print:**

**Today's Date:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
(First) (Last)

Present Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

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

**Who can we notify in case of an emergency?**

Name: \_\_\_\_\_ Daytime #: \_\_\_\_\_ Evening #: \_\_\_\_\_

**Primary Insurance:**

Name of Subscriber: \_\_\_\_\_ D.O.B: \_\_\_\_\_ SSN: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Claim Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Secondary / Supplemental Insurance:**

Name of Subscriber: \_\_\_\_\_ D.O.B: \_\_\_\_\_ SSN: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Claim Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_