Karle Medical Group, P.C.
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Rochester Hills, MI 48307
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Patient Demographic Information

Your Karle Medical Group Doctor: _____ Date: _____

Patient Information

Last Name _____First Name _____MI_____ Soc. Security #_____

Street Address_____ Suite/Apt # _____

City _____State _____ Zip-Code_____

Date of Birth _____ Sex _____ Marital Status_____

Cellular Phone _____ Work Phone _____Home Phone_____

May we leave messages? On (Y/N) Cell Phone _____Work Phone _____ Home Phone_____

Email:_____

Emergency Contact_____ Emergency Contact's Phone #_____

Preferred Language* _____Race/Ethnicity*_____ (If you decline to declare, write "Decline".)

Preferred Pharmacy Name and Cross Streets: _____ Pharmacy Phone_____

Responsible Party (Subscriber/Insurance Contract Holder) – the **4 bolded** items are required if you are not the insurance subscriber

Relationship between the patient listed above and the primary insurance holder? _____

RP Last Name _____ **RP First Name** _____MI____ Soc. Security #_____

Street Address_____ Suite/Apt # _____

City _____State _____ Zip-Code_____

RP Date of Birth _____ Sex _____ Marital Status_____

Home Phone _____ Work Phone _____Cell Phone_____

Insurance Information

Insurance Company_____ Subscriber Name_____

Insurance Contract Number _____Group Number _____Effective Date_____

Financial Responsibility Statement

This information is accurate and true to the best of my knowledge. I acknowledge and accept responsibility for payment of services rendered, including reasonable attorney's fees and costs of collection in the event of default. I understand that co-payment, deductibles, and patient balances are due at the time of service. If I do not pay at the time of service I will be charged a $5.00 account maintenance fee. I further understand that if a payment becomes 120 days past due, delinquency at the lesser of the annual rate of 26%, or the maximum allowable rate will be due on delinquent amounts from the date the payment was due. Any debt that is over 365 days overdue will be charged a 50% collection agency fee which will be required to be paid by the owing patient.

Signature:_____ Date:_____