New Patient Enrollment Form

ALF

NC Elder Care

This form is to be used when a resident requests our physician services. The form is to be completed and returned to the home office either by fax or e-mail prior to the physician visit.

NAME: _____

DOB: _____SOCIAL SECURITY: _____

PHONE NUMBER: _____HOME NUMBER: _____

ADDRESS:

_____

_____

Do you have insurance: ☐ **Yes** ☐ **No**

If so please provide us with a copy of your card.

Do you have a POA, Guardian or a Representative Party that you wish for us to communicate with? If so, provide the following information and provide any supporting legal documentation.

Name(print) _____

Address:

_____

Number: _____