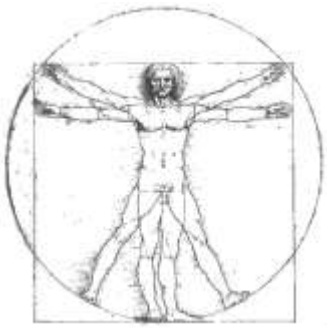

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555 Bridgeport Avenue
Shelton, CT 06484
Telephone: (203)225-0506
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Primary Care of Shelton, LLC

Last Name: _____ First Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Emergency Contact: _____

Birth Date: _____ Sex: M F

Social Security: _____ Marital Status: M S D SEP W

Insurance Company: _____

Policy Holder: _____

Relationship to insured: _____

Policy Number: _____

Group Number: _____

I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and, subject to the following restriction(s) concerning my personal medical information, I agree to the disclosures in the Notice. I also understand and agree to being charged up to $50.00 for a missed appointment as well as the $25.00 charge for any returned check. I agree that by signing this form authorizes Primary Care of Shelton to bill to my insurance company.

Patient's Signature: _____ Date: _____