PATIENT INFORMATION SHEET

Date: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: ( ) _____ Cellular Phone #: ( ) _____ e-mail: _____

Date of Birth: _____/_____/_____ Age: _____ Social Security #_____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed. Spouse/Next of Kin: _____ Phone #: _____

Employer: _____ Occupation: _____Work Phone #: _____

Name of Doctor you are here to see: _____ Referred to practice by: _____

Pharmacy: _____ Phone #: ( ) _____

Primary Care Provider: _____Primary Language Spoken: _____ Do you have a Living Will? _____

INSURANCE INFORMATION

Primary: _____
HMO POS PPO INDEMNITY

ID # _____

Group # _____

Claims Address: _____

_____
Subscriber: ☐ Spouse ☐ Self ☐ Dependent

_____
Subscriber's Social Security Number *or* Date of Birth

Phone Number: _____

Secondary:_____

ID # _____

Group # _____

Claims Address _____

_____
Subscriber: ☐ Spouse ☐ Self ☐ Dependent

_____
Subscriber's Social Security Number *or* Date of Birth

Phone Number: _____

Authorization for Test Results and Medical Information (Please check one or more of the following options**):**

☐ Leave a message at my phone number designated below if I am not available. ☐ Leave a message with anyone answering my phone.
☐ Name of other person(s) authorized to accept results for me: _____ Relationship: _____
☐ Speak with me **only**. ☐ **Do not call me with any results**. I will call the office if I want test results.

(_____) _____
Patient's Preferred Phone Number

(_____) _____
Alternate Phone Number

STATEMENT OF FINANCIAL RESPONSIBILITY

I certify that the above information is correct and further authorize the release of any medical information to your insurance carrier(s) for any claim. I request payment of authorized benefits for physician's services to the physician furnishing the service, or authorize the physician to submit a claim for me. I, the undersigned, realize that all medical and surgical charges incurred by me, or my dependents for services rendered are my financial responsibility. I also agree that should this account be referred to any agency or attorney for collection, I will be responsible for all collection fees, attorney fees and court costs. I am also aware that **payment is expected when services are rendered**, unless prior arrangements have been made.

Patient's Signature: _____ Date: _____

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Patient's Signature: _____ Date: _____