

PATIENT INFORMATION

Date: _____

Patient's Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ Work #: (_____) _____ Cell Phone #: (_____) _____

Social Security #: _____ Circle Sex: M F Marital Status: _____ Race: _____

Patient's Employer: _____ Occupation: _____ Email: _____

Contact in Case of Emergency: _____ Phone #: _____

Family Doctor: _____ Referring Doctor: _____

Insurance Information: (Please give receptionist your card.)

Primary Insurance: _____ Phone #: _____

Insured Name: _____ Relation to Patient: _____

Insured Policy ID #: _____ PT Policy ID #: _____

Insured DOB: _____ Insured Employer: _____ Insured SS #: _____

Insurance coverage provided through: Employer Individual Policy Workers Comp. Auto Accident Policy

Secondary Insurance: _____ Phone #: _____

Insured Name: _____ Relation to Patient: _____

Insured Policy ID #: _____ PT Policy #: _____ Group #: _____

Insured DOB: _____ Insured Employer: _____ Insured SS #: _____

Insurance coverage provided through: Employer Individual Policy Workers Comp. Auto Accident Policy

If Medicare is secondary circle reason: working spouse has insurance Veteran disabled other: _____

If Patient is a Minor:

Mother's Name: _____ Date of Birth: _____ Home Phone #: _____

Mother's Employer: _____ Bus. Phone #: _____ Social Security #: _____

Father's Name: _____ Date of Birth: _____ Home Phone #: _____

Father's Employer: _____ Bus. Phone #: _____ Social Security #: _____

Please read and sign below:

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize my physician 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 my physician on claims for which they have accepted assignment, and I authorize the physician to submit a claim to Medicare for payment on my behalf. I request that payment under the medical insurance program be made to my physician on any bills for services furnished me by my physician for which they have accepted assignment. I further release my physician to release medical information concerning my treatments to Blue Shield or other insurance carriers and I authorize payment of medical benefits from those carriers to be made directly to my physician on claims for which they have accepted the assignment. I also understand that I am responsible for payment for services not covered by the Medicare program.

I also authorize my physician's office to provide my medical information to other organizations or entities for the determination and payment of benefits. I authorize my physician's office to permit my insurance companies or third party payors to review / audit my medical chart if they so request. I assign benefits otherwise payable to me to my physician. I understand that I am financially responsible for the charges for any services rendered to me by my physician(s).

I have reviewed the practice's **PRIVACY POLICY** _____ (initial here).

I have reviewed the **OFFICE FINANCIAL POLICY** _____ (initial here).

I have reviewed the **CONSENT for TREATMENT** _____ (initial here).

I understand that copies are available upon request.

Signature: _____ Date: _____

If this is a workers compensation visit or auto accident account we must have that information on an additional form. Please ask the receptionist for the appropriate paperwork. Private insurance requires a copay to be paid at the time of service, if applicable.