

PATIENT INFORMATION SHEET

PATIENT (Mr./mrs./ms.) \_\_\_\_\_ Date \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Sex: m/F Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Hm) \_\_\_\_\_ Cell \_\_\_\_\_ Email: \_\_\_\_\_

employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Marital Status: Single/married/divorced/widowed/other: \_\_\_\_\_

Ethnicity: Latino/Hispanic/non-latino/Hispanic

Race: Caucasian/African American/Asian/native am/Alaskan native/Hawaii native/pacific islander/refuse to answer

referred by \_\_\_\_\_ Primary Care Doctor \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

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Primary Insurance \_\_\_\_\_ ID \_\_\_\_\_

Insured's name \_\_\_\_\_ Insured DOB \_\_\_\_\_ Insured SS# \_\_\_\_\_ Relation \_\_\_\_\_

secondary insurance \_\_\_\_\_ id \_\_\_\_\_

insured's name \_\_\_\_\_ Insured DOB \_\_\_\_\_ Insured SS# \_\_\_\_\_ RELATION \_\_\_\_\_

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MEDICARE SECONDARY PATIENTS:

IF MEDICARE IS YOUR SECONDARY INSURANCE PLEASE INDICATE THE TYPE OF BENEFIT YOU ARE RECEIVING. THIS ENSURES YOUR CLAIM WILL BE PROCESSED IN A TIMELY FASHION.

\_\_\_ 12 WORKING AGED

\_\_\_ 41 BLACK LUNG

\_\_\_ 13 END STAGE RENAL DISEASE

\_\_\_ 43 DISABILITY INSURANCE

\_\_\_ 14 AUTO NO FAULT INSURANCE

\_\_\_ 47 LIABILITY INSURANCE

\_\_\_ 15 MSP WORKERS COMPENSATION

\_\_\_ 17 WORK COMP MEDICAL SET ASIDE

\_\_\_ 16 FEDERAL

fees and payments:

please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. we submit claims to your insurance as a *courtesy*. it is

**your** responsibility to pay any deductible or co-insurance or any outstanding balance not paid for by your insurance company. \*\*my signature on file is my authorization for the release of information necessary to process my claim(s). \*\*\*if this account is turned over to collections I agree to pay all collection costs, attorney fees and/or court costs.

I hereby authorize payment directly to the physician named of the insurance benefits otherwise payable to me.

Signature \_\_\_\_\_

date \_\_\_\_\_