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 _____

****

Primary Insurance _____ID_____

Insured's name _____ Insured DOB _____ Insured SS# _____ Relation _____

secondary insurance _____id_____

insured's name _____ Insured DOB _____ Insured SS# _____ RELATION _____

****

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 _____