PATIENT INFORMATION FORM - 2016

(Form must be completed in full)

Patient

_____
first m.i. last

❑ Married ❑ Single ❑ Widowed ❑ Divorced

male
Date of Birth ____/_____/_____ Age_____ female

SS#_____

CDL#_____

Address _____

City _____ST____

Zip_____

Phone #_____ _____
home *cell*

Email

_____@_____

Occupation

_____

Employer _____

Ph#_____

Emp
Address_____

_____

Responsible for bill: <u>complete in full</u> or same as above

self spouse child employer other

Name

_____DOB_____

Address

_____

City _____ ST_____

Zip_____

Phone_____

_____
home *cell*

SS#

_____

Employer_____

_

Employer Address

_____

_____

Occupation

_____

How were you referred to our office?

Doctor Hospital Family Insurance Internet Friend

Name of person who referred
you_____

Were you recently seen in hospital by our doctors? Yes No

EMERGENCY CONTACT

Name _____

Relationship_____

PH

_____
home *cell*

Address_____

_

_____

Date _____

<u>INSURANCE INFORMATION :</u> (Insurance Cards required)

PPO HMO Medicare POS Cash WC Other

Primary Insurance

_____

Ins Address

_____

City_____ ST___

Zip_____

Subscriber _____

DOB_____

Member

ID#_____Grp#_____

Secondary

Ins_____

Ins Address

_____

Subscriber _____DOB

_____

Member

ID#_____Grp#_____

CURRENT LIST OF PHYSICIANS

Primary Care_____Ph

_____

Cardiologist

_____Ph_____

Gen

Surgeon_____Ph_____

Dermatologist_____Ph_____

Oncologist_____Ph_____

Other

_____

_____

_

PHARMACY Phone #

_____

Authorization for Payment/Release of Medical Records

I authorize release of medical records & payment of benefits to the physician and allow a photocopy of my signature to be used to file insurance. I understand that my insurance may not cover all fees and services provided and I will be responsible for the unpaid balance.

Signature _____

_____

(relationship to pt)

Photography Consent

I authorize the physician or his assistant to take photographs. The term "photograph: includes all standard & digital photographs, videotapes, etc.. These photographs are the doctor's property and will be a permanent part of the record.

Signature

_____Date_____

HIPAA Informed Release on File

(date)_____

(5-15)