PATIENT INFORMATION FORM – 2020

(Form must be completed in full)

Date _____

Patient _____
first m.i. last

❑ Married ❑ Single ❑ Widowed ❑ Divorced

Date of Birth ____/_____/_____ Age_____ ❑ male ❑ female

SS#_____ CDL#_____

Address _____

City _____ST____ Zip_____

Phone #_____ _____
home *cell*

Email _____@_____

Occupation _____

Employer _____ Ph#_____

Emp Address_____

_____

Responsible for bill: complete in full 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_____

_____

INSURANCE INFORMATION : (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)_____