

Patient Information Sheet

Today's Date _____

Name: First _____ MI _____ Last _____

DOB: _____ Sex: male ___ female ___ SS# _____

Address: Street _____ City _____ State _____ ZipCode _____

Mailing Address (if different than above):

Street _____ City _____ State _____ ZipCode _____

Home Phone# _____ Cell Phone _____

Employer: _____ Phone# _____

If Minor, Parent's Name _____

Person Responsible for bill, if other than above:

Name: _____ Relationship: _____

Address: _____ Phone# _____

Emergency Contact: _____ Phone# _____

Referring Physician: _____ Phone# _____

Primary Physician _____ Phone# _____

Pharmacy _____ Location _____

Race: _____ Ethnicity: _____ Language: _____

White	Spanish/Hispanic Origin	English
Black/African American	Not of Spanish/ Hispanic Origin	Spanish
American Indian/Alaska Native	Patient Declined/ Unknown	Other- (list)
Asian		Patient Declined/ Unknown
Native Hawaiian/ Other Pacific Islander		
Other- (list)		
Patient Declined/ Unknown		

Patient/Parent Signature _____ DATE _____

Print name _____

INSURANCE

NAME: _____ **Date of Birth:** _____

If you have Medicare and another insurance, see the section below to help determine which is first.

PRIMARY INSURANCE: MEDICARE HMO PPO POS COMMERCIAL

Name of Company: _____

ID# _____ Suffix _____ Group# _____

Primary Card Holder: _____ DOB _____

SECONDARY INSURANCE: MEDICARE HMO PPO POS COMMERCIAL

Name of Company: _____

ID# _____ Suffix _____ Group# _____

Primary Card Holder: _____ DOB _____

TERTIARY INSURANCE (3RD): MEDICARE HMO PPO POS COMMERCIAL

Name of Company: _____

ID# _____ Suffix _____ Group# _____

Primary Card Holder: _____ DOB _____

IS MEDICARE YOUR PRIMARY?

- Do you have a Medicare Advantage policy such as Senior Blue, MVP Gold, etc? These are Medicare Replacement policies and take over for Medicare.
- Do you have a supplemental insurance policy such as AARP. These are supplemental to Medicare and are second.

DO YOU HAVE MEDICARE BASED ON AGE?-If so:

Do you also have any coverage (group health plan) through employment of yourself or a spouse?

How many employees work for the sponsor of the group health plan?

If less than 20 employees- Medicare is primary.

If more than 20 employees- The group health coverage is primary.

DO YOU HAVE MEDICARE BASED ON DISABILITY – If so:

Do you also have any coverage (group health plan) through employment of yourself or a spouse:

How many employees work for the sponsor of the group health plan?

If less than 100 employees –Medicare is primary.

If more than 100 employees –The group health plan coverage is primary.

Financial policy:

Your insurance policy is a contract between you and your insurance company. Professional care is provided to you, our patient and not an insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We gladly process your claim, but request your estimated portion be paid at the time of service. To do so, we require your complete insurance information. In the event we do accept assignment of benefits, please know that the balance of your bill is still your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 30 days, you will have 30 days to arrange payment of the balance due. Regarding insurance plans in which we are a participating provider, please understand that we do require payment of co-pays and deductibles prior to treatment.

SIGNATURE

DATE