

PATIENT INFORMATION New Patient Name Change Address Change Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date _____

Name _____

Date of Birth: ____ / ____ / ____ Age: ____ Social Security _____ Gender: Male Female

Mailing Address _____ City _____ State _____ Zip _____

Home #: _____ Work #: _____ Cell #: _____

Marital Status: Single Married Divorced Widowed Separated INITIALS _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name _____ Date of Birth: ____ / ____ / ____

Address: _____ City _____ State _____ Zip _____

Home #: _____ Work #: _____ Cell #: _____

INSURANCE COVERAGE – PRIMARY:	INSURANCE COVERAGE – SECONDARY:
Insurance Co. Name: _____	Insurance Co. Name: _____
Phone #: _____	Phone #: _____
Address of Claim Center: _____	Address of Claim Center: _____
City _____ State Zip _____	City _____ State Zip _____
Name Policy Holder (Insured): _____	Name Policy Holder (Insured): _____
Date of Birth: ____ / ____ / ____ SS# _____	Date of Birth: ____ / ____ / ____ SS# _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Policy #: - _____	Policy #: - _____
Group Name or #: _____	Group Name or #: _____
Policy Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO	Policy Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO
Employer Name: _____	Employer Name: _____
If patient is child, check relationship:	If patient is child, check relationship:
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> other _ _____	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> other _ _____

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY, AND SIGNATURE ON FILE

Referred by: _____ Other family members that are patients _____

Primary care doctor: _____ Phone #: _____

In case of emergency, who should be notified? _____ Phone #: _____

Do you give our office permission to discuss your medical information with family members?

Yes No If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____ **Date** ____ / ____ / ____

PAYMENT POLICY:

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual \$100.00 deductible and paying of the 20% co-payment. We do file secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patient will be balance billed.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, co-payment, and charges for any non-covered, cosmetic services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature _____ **Date** ___/___/___

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card _____ **Date** ___/___/___

If you have a supplemental policy and it is a **MEDIGAP** policy to which your Medicare carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Medigap Card _____ **Date** ___/___/___

ATTACH A COPY OF PATIENT'S INSURANCE CARD (BOTH SIDES)