Partners In Health Patient Information Sheet

Please Fill Out Completely and Sign Where Indicated

Date _____/_____/_____

_____ _____ _____ _____

LAST NAME FIRST NAME M.I. NICKNAME

_____ _____ _____ _____

STREET ADDRESS OR P.O. BOX, INCLUDE APT. # CITY STATE ZIP CODE

GENDER (circle): Male or Female Date Of Birth_____/_____/_____ SSN_____/_____/_____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____ May we leave messages? YES NO

Email _____@_____ May we contact you via email? YES NO

EMPLOYER_____ OCCUPATION_____

WORK PHONE (_____)_____-_____ Is it okay to contact you at work? (circle) YES NO

IS THE PATIENT A STUDENT? (circle) YES NO SCHOOL NAME_____

MARITAL STATUS: (circle) SINGLE MARRIED SIGNIFICANT OTHER SEPARATED DIVORCED WIDOWED

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐Insurance ☐Advertisement ☐Online

☐ Referred by another doctor (who)_____ ☐ Referred by a friend (who)_____

PRIMARY POLICY HOLDER/GUARANTOR INFORMATION

(Parent/Guardian of minor children must supply their information even if child carries their own insurance)

_____ _____ _____ _____

LAST NAME FIRST NAME M.I. NICKNAME

_____ _____ _____ _____

STREET ADDRESS OR P.O. BOX, INCLUDE APT. # CITY STATE ZIP CODE

Date Of Birth_____/_____/_____ SSN_____/_____/_____ Relation To Patient_____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____ Work Phone (_____)_____-_____

EMPLOYER_____ OCCUPATION_____

EMERGENCY CONTACT/NEXT OF KIN

Name:_____ Phone: (_____)_____-_____Relationship:_____

INSURANCE INFORMATION

Payment is due when services are rendered, unless other arrangements have been made in advance. We will be happy to file a claim with your insurance carrier, if you can provide us with a legible copy of the front and back of your insurance card. This copy must include the name, address, and phone number of your insurance carrier, as well as the policy and group numbers at the time of your visit.

A COPY OF YOUR INSURANCE CARD IS REQUIRED FOR US TO MAKE A CLAIM

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize payment of medical benefits to the undersigned physician or supplier for these services, and all future services.

I authorize the release of any medical information necessary to process this claim, and all future claims.

This physician is not responsible for any dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your insurance provider or employer.

I UNDERSTAND THAT, SHOULD I NEED TO CANCEL AN APPOINTMENT, IT MUST BE DONE WITHIN 24 HOURS OF THE APPOINTMENT DAY, OR I WILL BE CHARGED A "NO-SHOW" FEE.

Signed by Insured or Authorized Person_____ Date_____/_____/_____