Associates In Internal Medicine, P.C.

Patient Information Sheet

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PATIENT DEMOGRAPHICS

Referred By:____ Today:_____________________________

Patient Name:____ M.I.____________

LAST FIRST

Patient Address ____

Street Address Apt# City State Zip

Home Phone: (_______)______________________ Date of Birth:__________________________________

Social Security Number:______________________________________(This must be your personal number, not a spouse or the policy holder of your plan)

Sex: _______ Male ________ Female Marital Status:____

Patient Employed By:____

Responsible Party Name:____Relationship:________________

(If other than patient) LAST FIRST M.I.

Responsible Party Address:____

Street Address Apts# City State Zip

Cell Phone Number:__________________________________ Work Number/Ext:_____________________________

EMERGENCY CONTACT:________________________________ EMERGENCY PHONE:_________________________

Relationship

INSURANCE COVERAGE INFORMATION

Primary Insurance Carrier:____ Telephone#_________________________

Print Name of Insurance Carrier

Subscriber Name:____ Date of Birth:_________________________

Subscribers Relation to Patient:____

Member Identification#:__________________________________ Group#:_______________________________________

Group Name/Employer:____

Mailing Address for Claims:____

Please Print. Address is on the back of your insurance card. Thank you

Assignment of Benefits and Waiver of Liability

I hereby authorize the release of medical information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further authorize payment for all billed services to be made directly to Assoc. in Internal Medicine, P.C.. I understand and agree to be financially responsible for any balance not covered by my insurance plan. I understand that Self Paying patients are responsible for payment in full on the day services are rendered.

____ ____________________

Signature of Subscriber/Spouse/Responsible Party **Date**

I, the undersigned have agreed to provide Assoc. in Internal Medicine, P.C. with the necessary referral and documents to bill my insurance plan. If I elect to be seen without a referral, I agree to accept financial responsibility for all charges incurred. If the referral I provide is not valid for the services rendered, I will be responsible for all balances due to Assoc. in Internal Medicine, P.C. I accept this responsibility on behalf of myself and/or my dependents.

____ ____________________

Signature of Subscriber/Spouse/Responsible Party **Date**