PATIENT INFORMATION □ New Patient □ Name Change □ Address Change □ Insurance Change

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

Name ____
Last *First* *M.I.*

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: ____/____/____
Last *First* *M.I.*

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: □ Male □ Female	Sex: □ Male □ Female
Policy #: -_______________________________	Policy #: -_______________________________
Group Name or #: _________________________	Group Name or #: _________________________
Policy Type: □ HMO □ PPO	Policy Type: □ HMO □ PPO
Employer Name: ___________________________	Employer Name: ___________________________
If patient is child, check relationship:	If patient is child, check relationship:
□ Mother □ Father □ other _ _______________	□ Mother □ Father □ other _ _______________

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY, AND SIGNATURE ON FILE

Referred by: _________________________ Other family members that are patient's ____________________

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)