Patient Information

Date: ____________________

Name: ____ Birth date: _____/_____/______

Sex: M F Preferred pronoun _______ How would you like to be addressed?_________________________

Marital Status: S M W D SS#_______________________________________

Address ____
Street City State Zip

Home Phone# (_____)__________________________ Cell Phone # (____)________________________________

Employer _______________________Occupation________________________Phone#___________________

Address ____
Street City State Zip

Referring Physician: __________________________________Phone# ( )___________________________

Address ____
Street City State Zip

Name of spouse/partner ____________________________________ Birth date_______________________

If minor, parent or guardians name ______________________________ Relationship __________________

Nearest friend or relative not residing with you ____________________________ Phone# ______________

Primary Insurance____________________________ ID # ____

Enrollee Name _______________________________Enrollee Date of Birth _____/_____/_______

Secondary Insurance ___________________________ID# ____

Enrollee Name _______________________________ Enrollee Date of Birth _____/_____/_______

Patient Authorization

Medicare Patient Authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Financing Administration or its intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim/other Insurance Company 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 to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party responsible for paying for my treatment.

MEDICARE PATIENT SIGNATURE:__________________________________**DATE:**________________________

Release of Information: I authorize my physician to furnish any information acquired in the course of my examination or treatment to the above referring physician or to any physician I may be referred to.

I hereby authorize the release of any medical or other information necessary to process all claims. I hereby authorize payment to my physician of benefits otherwise payable to me. I understand that I am financially responsible to the doctor for any amount not covered by my insurance.

Authorization for Lab Services: I understand that any specimen that is removed may be sent to a laboratory for a clinical diagnosis and that I may be responsible for any laboratory fees incurred.

PATIENT, PARENT, OR GUARDIAN SIGNATURE: ____________________________**DATE:** __________________