PATIENT INFORMATION - 2024

DATE: _____

PATIENT NAME: _____ M OR F (CIRCLE ONE)

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PATIENT HOME PHONE: _____

PATIENT DATE OF BIRTH: _____

PATIENT SCHOOL NAME: _____

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN'S NAME: _____

MARITAL/LEGAL STATUS: _____

ADDRESS: _____

PHONE: _____

E-MAIL: _____

EMPLOYER: _____ PHONE: _____

PARENT/GUARDIAN'S NAME: _____

MARITAL/LEGAL STATUS: _____

ADDRESS: _____

PHONE: _____

E-MAIL: _____

EMPLOYER: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____

CONTACT PHONE: _____

INSURANCE INFORMATION

PRIMARY CARRIER: _____

POLICY HOLDER NAME: _____

POLICY HOLDER ADDRESS: _____

POLICY HOLDER PHONE: _____

POLICY HOLDER DATE OF BIRTH: _____

MEMBER ID: _____ GROUP NUMBER: _____

SECONDARY CARRIER: _____

POLICY HOLDER NAME: _____

POLICY HOLDER ADDRESS: _____

POLICY HOLDER PHONE: _____

POLICY HOLDER DATE OF BIRTH: _____

MEMBER ID: _____ GROUP NUMBER: _____

AUTHORIZATIONS

ARE YOU THE PATIENT'S LEGAL GUARDIAN? YES OR NO

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS.

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF BENEFITS

I AUTHORIZE DIRECT REMITTANCE OF PAYMENT OF ALL INSURANCE BENEFITS, INCLUDING MEDICARE. IF I AM A MEDICARE BENEFICIARY TO THIS PROVIDER FOR ALL COVERED MEDICAL SERVICES AND SUPPLIES PROVIDED TO ME. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR ANY OTHER INFORMATION TO THE CENTERS FOR MEDICARE AND MEDICAID (CMS), MY INSURANCE CARRIER(S); OR OTHER ENTITY NECESSSARY TO DETERMINE INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED MEDICAL SERVICES AND/OR SUPPLIES PROVIDED TO ME BY THIS PROVIDER. A COPY OF THIS AUTHORIZATION WILL BE SENT TO CMS, MY INSURANCE CARRIER(S), OR OTHER MEDICAL ENTITY, IF REQUESTED. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

I HAVE READ THE HIPAA NOTICE FORM.

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____