

# WELCOME

## 1

### PATIENT INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_  
 First Middle Last

Date of Birth \_\_\_\_\_ Sex M  F

SSN# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Age: \_\_\_\_\_

#### Marital Status

Married  single  widowed  
 divorced  separated

#### Employment:

\_\_\_\_\_  
 Name of company

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Position

#### Spouse's information:

Spouse's Name \_\_\_\_\_  
 First Middle Last

Birth date \_\_\_\_\_ SSN: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Employer: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 3

### CONTACT INFORMATION

Home # ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell # ( ) \_\_\_\_\_ - \_\_\_\_\_

What is the best time to contact you? \_\_\_\_\_  
 In case of an emergency, contact: \_\_\_\_\_

\_\_\_\_\_  
 Name Relationship

\_\_\_\_\_  
 Phone# Work phone#

Date of last physical examination \_\_\_\_\_  
 What is your reason for visit? \_\_\_\_\_

## 4

### FAMILY HISTORY

ALIVE DECEASED	FATHER <input type="checkbox"/> <input type="checkbox"/>	Present health or cause of death	MOTHER <input type="checkbox"/> <input type="checkbox"/>	Present health or cause of death	SPOUSE <input type="checkbox"/> <input type="checkbox"/>	Present health or cause of death
BROTHERS	No. Alive	HEALTH		No. Deceased		
SISTERS						
CHILDREN						

**CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES.**  Diabetes  Cancer  Bleeding tendency  
 Tuberculosis  Heart Disease  Stroke  High Blood Pressure  Nervous Illness  Allergy  Other

## 2

### INSURANCE

Who is responsible for this account? \_\_\_\_\_

Name: \_\_\_\_\_  
 First Middle Last

Relationship to the Patient: \_\_\_\_\_

Birth date: \_\_\_\_\_ SSN# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group # \_\_\_\_\_

Is the Patient covered by additional insurance?  Yes  No

Subscriber's name: \_\_\_\_\_

Birth date: \_\_\_\_\_ SSN# \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group # \_\_\_\_\_

#### ASSIGNMENT AND RELEASE

I the undersigned certify that I, (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
 Signature of Responsible Party

\_\_\_\_\_  
 Relationship Date

#### MEDICAL AUTHORIZATION

I request that the payment of authorized Medicare benefits be made either to me or on my behalf to Dr. \_\_\_\_\_ for any services furnished me by that physician. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare Carrier, as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
 Beneficiary's Signature Date