PATIENT INFORMATION SHEET

NAME_____BIRTHDATE_____ MALE FEMALE

ETNICITY: White Black Asian American-Indian Hispanic other_____

PRIMARY LANGUAGE: English Spanish French other_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE/CELL_____WORK_____

EMRGENCY CONTACT NAME + PHONE#:_____

FAMILY PHYSICIAN: _____

OTHER PHYSICIANS TO CONTACT: _____

SS#_____EMPLOYER_____

MARITAL STATUS: _____NAME OF SPOUSE: _____

PERSON WHO CARRIES INSURANCE: _____

_____

I authorize any holder of medical or other information about me to release my designated insurance company or to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this 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 to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (section 1128 of the Social Security Act and 31 U.S. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare of benefits also apply.

I AGREE TO PAY WHATEVER BALANCE MY INSURANCE DOES NOT COVER. I WILL MAKE PAYMENT ARRANGEMENTS IF NECESSARY. IF A REFERRAL IS REQUIRED BY MY INSURANCE I UNDERSTAND IT IS MY RESPONSIBLITY TO CONTACT MY PRIMARY PHYSICIAN TO MAKE SURE ONE IS MADE OR ELSE I WILL BE CONSIDERED A SELF PAY PATIENT AND WILL PAY MY BILL IN FULL.

Signature_____Date: _____