PATIENT INSURANCE INFORMATION

PATIENT

Name

☐ Male ☐ Female
☐ Single ☐ Married
☐ Separated ☐ Divorce

Address

Birthdate Age

City State Zip

Social Security Number

Home Telephone Drivers License Number/State

Religious Preference

PATIENT EMPLOYER

Company

Address

City State Zip

Telephone Extension

Insurance Name

Address

City State Zip

Group Policy # SS#

Policy Effective Date

Telephone ( )

Is this the primary insurance policy? ☐ Yes ☐ No

SPOUSE'S EMPLOYER

Spouse's Name DOB

Company

Address

City State Zip

Telephone Extension

Insurance Name

Address

City State Zip

Group Policy # Spouse's SS#

Policy Effective Date

Telephone ( )

Is this the primary insurance policy? ☐ Yes ☐ No

Relative or friend not living with you

Name

Address

City State Zip

Home Telephone Business Telephone

How were you referred to this office?

Name

Other Physician

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician and hospital. It is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible, copayment or other balances not paid for by your insurance.

I authorize my physician and the hospital to release to my insurance company or any third party, any information, including diagnosis and records of such treatment as necessary to determine my eligibility for any procedure, my liability for payment, and to obtain reimbursements.

I also authorize and request my insurance companies to pay directly to my physician and to the hospital, the amount due in my pending claim for surgical and medical care. I understand that I am financially responsible for all charges regardless of the insurance status, and am aware that all outstanding balances will be subject to finance charges as listed separately.

Signed _____ **Date** _____

MEDICAL QUESTIONNAIRE

MEDICAL HISTORY

LAST NAME _____ FIRST _____ AGE _____ HEIGHT(Ft/In) _____ CURRENT WT. _____

OCCUPATION _____ DATE OF BIRTH _____ HOW LONG AT CURRENT WEIGHT? _____

MARITAL STATUS: M S W D

RACE: ☐ White ☐ Black ☐ Asian ☐ Native American ☐ Hispanic

PRIMARY HEALTH CARE PROVIDER

NAME: _____

ADDRESS: _____

PHONE: _____

How long has she/he provided medical care for you? _____

Conditions treated: _____

_____

_____

If you are also under the care of other practitioners, please provide details: _____

_____

_____

_____

WHO IS THE FIRST PERSON TO NOTIFY IMMEDIATELY FOLLOWING SURGERY?

NAME: _____

RELATIONSHIP: _____

PHONE:(check where to call) ☐ Home _____ ☐ Work _____

Will she/he be waiting at the hospital during your surgery? ☐ Yes ☐ No

Today's Date: _____ Pt. Name: _____