PATIENT INFORMATION SHEET

Date ___________

Name: ____

Street Address: ____

City: ________________________________ State: ____________ Zip: __________

Home Phone #: (   ) ________________ Cellular Phone #: (   ) ______________

e-mail: _______________________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Relationship

Date of Birth: _____/_____/______ Age: ______ Social Security # ________ - _______ - ______

Employer: ____________________________________Occupation: ________________

Work Phone #: ________________________ Extension: ________

Spouse/Next of Kin: ____________________________ Phone #: (   ) ___________

Referred to practice by: ____

Name of Doctor you are here to see: ___________________________________

Pharmacy: ___________________________________ Phone #:(   ) ___________

Primary Language Spoken: ________________ Do you have a Living Will? __________

INSURANCE INFORMATION

Primary: ________________________________

HMO POS PPO INDEMNITY

ID # ________________________________

Group # ________________________________

Claims Address: ________________________________

____

Subscriber: Spouse Self Dependent

____

Subscriber's Social Security Number *or* Date of Birth

Phone Number: ________________________________

Name of Primary Care Provider: ____________________

Secondary: ________________________________

ID # ________________________________

Group # ________________________________

Claims Address: ________________________________

____

Subscriber: Spouse Self Dependent

____

Subscriber's Social Security Number *or* Date of Birth

Phone Number: ________________________________

Phone #: (   ) ________________________________

STATEMENT OF FINANCIAL RESPONSIBILITY

I certify that the above information is correct and further authorize the release of any medical information to your insurance carrier(s) for any claim. I request payment of authorized benefits for physician's services to the physician furnishing the service, or authorize the physician to submit a claim for me. I, the undersigned, realize that all medical and surgical charges incurred by me, or my dependents for services rendered by Mark B. McCormick, M.D., Bradley S. Douglas, M.D., Alexandra C. Lieberman, D.O., Alexandria M. Angelides, M.D., and/or Patricia M. Deitz, M.D. are my financial responsibility. I also agree that should this account be referred to any agency or attorney for collection, I will be responsible for all collection fees, attorney fees and court costs. I am also aware that **payment is expected when services are rendered**, unless prior arrangements have been made.

Patient's Signature: ____________________________________ Date: ______________

MEDICARE LIFETIME AUTHORIZATION

"I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me."

Patient's Signature: ____________________________________ Date: ______________