PATIENT INFORMATION FORM

PATIENT INFORMATION

Name ______________________________ __________________________ _________________
Last First Middle

Home Address ____

City ___________________________ Zip______________

Date of Birth __________________ SS#_______________________

Occupation ___________________________ Place of Employment_________________________________

Home Phone______________________ Cell Phone _________________Work Phone _________________

Email Address ____

Policy Holder Information

Name _____________________________ ___________________________ _________________
Last First Middle

Home Address ____

City ___________________________ Zip______________

Date of Birth __________________ SS#_______________________

Occupation ___________________________ Place of Employment_________________________________

Home Phone______________________ Cell Phone _________________Work Phone _________________

INSURANCE

Insurance Information (Please give your insurance(s) and Photo ID to the receptionist):

Primary Insurance Company's Name ____

Subscriber # ____

Member ID # ________________________________Group # _____________________________________

Secondary Insurance Company's Name ____

Subscriber # ____

Member ID # ________________________________Group # _____________________________________

EMERGENCY CONTACT (Please put parent\guardian if minor – unless other is desired)

Name

____Relationship______________________________

Last   First

Home Address ____

City ____________________________ Zip _______________

Insurance Assignment and Releases

I, the undersigned, hereby assign, transfer and set over to Mountain View Internal Medicine & Pediatrics all my rights, title and interest in and to medical and/or surgical benefit payments to which I am entitled resulting from medical and/or surgical services performed for me by Mountain View Internal Medicine & Pediatrics and I direct my insurance company to pay any and all such entitlements directly to Mountain View Internal Medicine & Pediatrics.

____ ____________________________

Signature   Date

I understand that all co-pays and deductibles are to be paid at the time of service. In the event that my account becomes delinquent and must be turned over to a collection agency or attorney, I authorize the release of any medical information necessary to process an insurance claim and I authorize payment of medical benefits directly to Mountain View Internal Medicine & Pediatrics. I understand that my insurance policy is a contract between my insurance company and myself and that I am financially responsible for charges not covered by the policy. I will assist in the collection of my insurance benefit should there be any delay on payment.

I have received the attached "Notice of Privacy Policy" detailing how my information may be used and disclosed as permitted under federal and state law, and a copy of the office financial policy.

____ ____________________________

Signature   Date

Whom May we thank for referring you? ____