PATIENT CONFIDENTIAL PROFILE

ALL MEDICAL SERVICES ARE PAYABLE AT THE TIME THE SERVICE IS RENDERED
WE DO NOT GUARANTEE ANY SERVICE WILL BE COVERED BY INSURANCE
(Please Print)

Today's date:	email:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ BCBS	❑ AvMed	❑ UHC	❑ Medicare	❑ Medicaid

❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Insurance assignments and authorization to release information

I. Release of information: I, the below named patient, do hereby authorize any physician examining and/or treating me to release any third payor (such as insurance company or Governmental agency example: Blue Shield of Florida or Medicare) Any medical and Psychiatric information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. Physician insurance assignment: I, the below named subscriber, hereby authorize payment directly to any physician examining or treatment of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. Medicare/Medicaid: Patient's certification authorization to release and payment request. I certify that the information given by me in applying for payment under title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the Physician treating me.

IV. I permit a copy of these authorization and assignments to be used in place of the original, which is on file at the Physicians office. If Medicare patient, I understand this is a lifetime authorization.

I understand that I am responsible for payment of any services that are not paid by my insurance.

Note: You may receive a separate billing from an outside lab, Physician or Hospital for interpretation or results of lab work and /or pathology specimens collected in our office.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*