PATIENT INFORMATION RECORD

DATE : _____ PATIENT #: _____

Name: (Last) (First) (Middle)				Social Security Number:
Sex:	Date of Birth:	Race:	Age:	Marital Status: Single ___ Married ___ Widowed ___ Divorced ___
Address: (Street) (City) (State) (Zip)				
Telephone: Home: ( ) Work: ( ) Cell: ( )				
Please furnish summer address and phone number if different from above Address: (Street) (City) (State) (Zip)				
Email Address:				
Primary Language:	Ethnicity: Yes: Hispanic origin	**PLEASE CIRCLE ONE** No: Non-Hispanic origin	Unknown/Decline	
Family Physician:			Pharmacy: Location: Phone:	
Referred by Doctor YES NO Name of Doctor:			Referred by Friend YES NO Name of Friend:	
Patient's Employer:			Address:	
Spouse:			Employer:	
Emergency Contact Person:			Telephone:	

WE FILE ALL INSURANCE CLAIMS

PLEASE PRESENT ALL INSURANCE CARDS TO RECEPTIONIST TO BE COPIED

PATIENT'S RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION FORM

LIFETIME AUTHORIZATION MEDICARE

Patient's certification, authorization to release information and payment request. 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 performing the services.

Signature X _____

(Patient or Authorized Representative) (Signature by Mark must be Witnessed)

WITNESS _____ DATE _____

INSURANCE (other than Medicare) PATIENTS

I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignments.

DATE _____ **SIGNATURE X** _____

I authorize payment of medical benefits to undersigned physician or supplier for service described

DATE _____ **SIGNATURE X** _____

11-2016