

PATIENT INFORMATION

PATIENT _____
last first middle

Address _____
street city state zip county

Home Phone _____ Phone # during the day _____ Sex M ___ F ___

Birthdate ____ - ____ - ____ Race _____ Age ____ SS# ____ - ____ - ____ Married: Y ___ N ___

Employer or School _____
name & address

phone number job title full or part time

Parent or Spouse: _____
first & last name Parent or Spouse's SS# _____ Birthdate _____

Parent or Spouse's Employer _____
name & address phone number

GUARANTOR INFORMATION

GUARANTOR _____
last first middle

Address _____
street city state zip county

Phone # _____ SS# ____ - ____ - ____ Relationship to Patient _____

Employer _____
name & address phone number

Nearest relative not living with patient - Name: _____

Address _____
street city state zip county

Phone# _____ Relationship: _____

Please be prepared to bring the following with you to every doctor's visit:

- 1) **Your most recent insurance card.**
- 2) **Your copay, if you have one.**
- 3) **A list of ALL current medications you are taking.**
- 4) **If you have a deductible or an HSA plan, you will be asked to pay the % amount due from you AT THE TIME OF VISIT**

Please understand that failure to do any of the above may result in your appointment being rescheduled for another day or time.

Signed: _____ **Date:** _____

I hereby grant permission to Internal Medicine & Pediatric Associates to administer medication and/or perform needed medical treatment. I hereby assign all benefits payable to Internal Medicine & Pediatric Associates and understand that the balance not paid by my insurance company and/or predetermined to not be covered by my insurance company will be my responsibility.

Signed (patient) _____ Date _____

Signed (guarantor) _____ Date _____

MEDICARE PATIENTS - I authorize any holder of medical or other information about me to release to the Social Security Administration and HCFA or its intermediaries or carrier of any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of benefits to Internal Medicine & Pediatric Associates. Regulations pertaining to Medicare assignment of benefits apply.

Signed (patient) _____ Date _____