Breen Family Medicine Patient Demographic Form

Patient Information

Name (Last, First, MI)			Today's Date
Street Address	City	State	Zip
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	
SSN	Date of Birth	Gender ☐ Male ☐Female	Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated □ Partner □ Other
Race	Ethnicity	Preferred Language	Email address

Financially Responsible Party

Is patient responsible party/guarantor? ☐Yes☐No(If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)

Name	Address	City/State/Zip	Relationship to Patient
Occupation	Employer	Email Address	Date of Birth
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	

Emergency Contact

Name	Relationship to Patient	
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

Referral Info

Referring Physician's Name	Physician Phone/Fax (if known) ( )
Physician Address	

PCP Info

Previous Primary Care Physician	Physician Phone/Fax (if known) ( )
Physician Address	

Insurance Information

Primary Insurance Company		Policy #	Group #
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____		Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐Female	Date of Birth	Employer of Subscriber / Work Phone ( )
Secondary Insurance Company		Policy #	Group #
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____		Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber / Work Phone ( )

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: _____/_____/_____

Guarantor Signature (if other than patient):_____ Date: _____/_____/_____

Because there are so many different insurance plans it is impossible for us to know if we are contracted with your specific plan. Therefore, it is the patients responsibility to know their individual plan and if the provider they are seeing is in-network.

_____
Initials

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of Breen Family Medicine's Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in Breen Family Medicine's Notice of Privacy Practices, please do not hesitate to contact a clinic representative.

_____ _____

Patient Name (Printed): Patient Representative and relationship:

_____ _____

Signature: Date Notice Received:

Release of Information

☐I authorize the release of information including the diagnosis, records; Examination rendered to me and claims information.

This information may be released to:

☐Spouse: _____

☐Child(ren): _____

☐Other: _____

☐Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:

☐my home: _____

☐my work: _____

☐my cell: _____

If unable to reach me:

☐you may leave a detailed message

☐please leave a message asking me to return your call

☐do not leave a message

_____ _____

Signature: Date Signed:

BREEN
FAMILY MEDICINE

Due to the increased control of health care by insurance companies,
we explain the following services for your consideration

Annual Physical/Well Women/Well child exam

Insurance coverage *usually* includes:	This does NOT include:
-Physician Orders for screening tests	-Medical complaints
-Screening lab work	-Illnesses
-Preventative vaccinations	-Concerns which include but are not limited to: Depression, anxiety, upper respiratory infection, fatigue symptoms, hormonal imbalance, problems urinating, birth control, skin lesion removal, vaginal infections, weight management
-Breast exam/ Pelvic exam	
-Pap testing	

Your insurance company may **not pay 100% for your preventative visit or may bill you a co-pay** if you choose to discuss illness/non preventative complaints during your preventative visit. We are happy to address additional medical concerns at this visit as long as you are aware that you may potentially be billed by your insurance as a non-preventative visit.

I have read and understand the information stated above, and I understand that I am ***financially responsible*** for all services not paid by my insurance carrier.

Print Name: _____ DOB: _____

Signature: _____ Date: _____

Lab Information

Your provider may feel it necessary for you to have lab testing done. It is ***your responsibility*** to check with your insurance regarding which tests will be covered under the diagnosis listed on the lab requisitions. LabCorp and other third party labs routinely perform tests on specimens from our office. Therefore, you may receive a separate bill from one of these laboratories. It is ***your responsibility*** to know which laboratory your insurance will cover. If you have questions about lab prices or a bill you receive, please call number the listed on the bill, as we are not able to discuss outside accounts.

Signature: _____ Date: _____