PATIENT INFORMATION SHEET

Date _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: ( ) _____ Cellular Phone #: ( ) _____

☐ Relationship

e-mail: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth: _____/_____/_____ Age: _____ Social Security # _____ - _____ - _____

Employer: _____ Occupation: _____

Work Phone #: _____ Extension: _____

Spouse/Next of Kin: _____ Phone #: ( ) _____

Referred to practice by: _____

Name of Doctor you are here to see: _____

Pharmacy: _____ Phone #:( ) _____

Primary Language Spoken: _____ Do you have a Living Will? _____

INSURANCE INFORMATION

Primary: _____
HMO POS PPO INDEMNITY

ID # _____

Group # _____

Claims Address: _____

_____
Subscriber: Spouse Self Dependent

_____
Subscriber's Social Security Number *or* Date of Birth

Phone Number: _____

Name of Primary Care Provider: _____

Secondary: _____

ID # _____

Group # _____

Claims Address: _____

_____
Subscriber: Spouse Self Dependent

_____
Subscriber's Social Security Number *or* Date of Birth

Phone Number: _____

Phone #: ( ) _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I certify that the above information is correct and further authorize the release of any medical information to your insurance carrier(s) for any claim. I request payment of authorized benefits for physician's services to the physician furnishing the service, or authorize the physician to submit a claim for me. I, the undersigned, realize that all medical and surgical charges incurred by me, or my dependents for services rendered by Mark B. McCormick, M.D., Bradley S. Douglas, M.D., Alexandra C. Lieberman, D.O., Alexandria M. Angelides, M.D., and/or Brian E. Haley, M.D. are my financial responsibility. I also agree that should this account be referred to any agency or attorney for collection, I will be responsible for all collection fees, attorney fees and court costs. I am also aware that **payment is expected when services are rendered**, unless prior arrangements have been made.

Patient's Signature: _____ Date: _____

MEDICARE LIFETIME AUTHORIZATION

"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 furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me."

Patient's Signature: _____ Date: _____