

PATIENT INFORMATION SHEET

Patient Name: _____ Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ SS #: _____ Driver's License #: _____
 Birth Date: _____ Age: _____ Sex: *M* *F* Marital Status: *S* *M* *W* *D*
 Patient's Employer: _____ Employer's Phone #: _____
 Employer's Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ SS #: _____ Date of Birth: _____
 Spouse's Employer: _____ Spouse's Employer's Phone #: _____
 Spouse's Employer's Address: _____ City: _____ State: _____ Zip: _____
 Closest Relative: _____ Relationship: _____ Phone #: _____
 Emergency Contact: _____ Relationship: _____ Phone #: _____
 Referring Physician: _____

COMPLETE IF PATIENT IS A MINOR

Mother/Guardian: _____ Address: _____ City/State: _____ Zip: _____ Phone #: _____
 Employer: _____ Address: _____ City/State: _____ Zip: _____ Phone #: _____
 Father/Guardian: _____ Address: _____ City/State: _____ Zip: _____ Phone #: _____
 Employer: _____ Address: _____ City/State: _____ Zip: _____ Phone #: _____
 Mother/Guardian SS #: _____ Father/Guardian SS #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name and Address: _____
 Insured's Name: _____ Relationship: _____ SS #: _____
 Certificate #: _____ Date of Birth: _____ Group #: _____

SECONDARY INSURANCE

Insurance Company Name and Address: _____
 Insured's Name: _____ Relationship: _____ SS #: _____
 Certificate #: _____ Date of Birth: _____ Group #: _____

PLEASE READ AND SIGN ONE OF THE FOLLOWING STATEMENTS

MEDICARE AUTHORIZATION AND ASSIGNMENT: (PLEASE READ)

I request that payment of authorized Medicare benefits be made either to me or in my behalf to **PrimeCare Group of Inland Valley** for any services furnished me by that physician/supplier. I authorize any holder or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

 Signature of Beneficiary HIC Number Date
 (Medicare Number)

INSURANCE AUTHORIZATION AND ASSIGNMENT: (PLEASE READ)

I hereby authorize **PrimeCare Group of Inland Valley** to furnish information to insurance carrier concerning my illness and treatment and I hereby assign to the physician all payment for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by the insurance. When a payment is made to **PrimeCare Group of Inland Valley**, they have the right to apply the payment to any outstanding balances I may have with any physician at **PrimeCare Group of Inland Valley**.

I understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the credit grantor may add one and one half percent (1 1/2%) per month to any balance owed, and in event of default to pay reasonable collection charges and/or attorney fees. **Laboratory, Radiology, Physical Therapy and other Ancillary Services provided in connection with the Physician's office will be billed separately.**

 Responsible Party Signature Date