Association of Specialty Physicians, Inc.

PATIENT INFORMATION FORM

PATIENT INFORMATION:

NAME: LAST | FIRST | MIDDLE NAME | SEX ☐ M ☐ F | BIRTH DATE | AGE

ADDRESS: STREET | CITY | STATE | ZIP | TELEPHONE # ( )

EMAIL ADDRESS | CELL PHONE # ( )

MARITAL STATUS ☐S ☐M ☐W ☐SEP ☐DIV | SOCIAL SECURITY # | OCCUPATION | EMPLOYER PHONE ( ) | IF STUDENT ☐ PART-TIME ☐ FULL-TIME

NAME AND ADDRESS OF EMERGENCY CONTACT | TELEPHONE # ( )

EMPLOYER OR NAME OF SCHOOL | ADDRESS | STATE | ZIP CODE

RACE: (CIRCLE ONE) AMERICAN/AK INDIAN | BLACK/AFRICAN AMERICAN | ASIAN/PACIFIC ISLANDER | HISPANIC | WHITE/CAUCASIAN | UNKNOWN/DECLINE

ETHNICITY: (CIRCLE ONE) NOT OF HISPANIC ORIGIN | HISPANIC ORIGIN | UNKNOWN/DECLINE

WILL PATIENT BE BEST SERVED IN A LANGUAGE OTHER THAN SPOKEN ENGLISH?

_____ NO _____ YES IF YES, PLEASE SPECIFY _____

DOMINATE HAND: (CIRCLE ONE) LEFT RIGHT

SPOUSE, PARENT OR GUARDIAN INFORMATION:

NAME: LAST | FIRST | MIDDLE NAME | SEX ☐ M ☐ F | BIRTH DATE | AGE

ADDRESS: STREET | CITY | STATE | ZIP | TELEPHONE # ( )

EMAIL ADDRESS

☐SPOUSE ☐PARENT ☐OTHER | SOCIAL SECURITY # | EMPLOYER OR SCHOOL NAME AND ADDRESS

INSURANCE INFORMATION:

*** PLEASE SHOW CARDS TO RECEPTIONIST ***

IF AUTOMOBILE, JOB INJURY OR ACCIDENT, LIST RESPONSIBLE PARTY OR INSURANCE AS PRIMARY AND HEALTH INSURANCE AS SECONDARY.

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY

ADDRESS: | TELEPHONE # ( )

WHO OWNS THE POLICY? | BIRTH DATE | EFFECTIVE DATE

ID # OR AGREEMENT # | GROUP # | RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

OTHER INFO

SECOND OR CO-INSURANCE

NAME OF INSURANCE COMPANY

ADDRESS: | TELEPHONE # ( )

WHO OWNS THE POLICY? | BIRTH DATE | EFFECTIVE DATE

ID # OR AGREEMENT # | GROUP # | RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

OTHER INFO

(OVER)

HEALTH QUESTIONS

PATIENT NAME

1. BRIEFLY DESCRIBE WHY YOU ARE VISITING OUR OFFICE:

2. IF CONDITION IS DUE TO AN ACCIDENT, PLEASE DESCRIBE NATURE OF ACCIDENT:

DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

DATE OF DISABILITY	RETURN TO WORK DATE

3. DID YOU HAVE X-RAYS DONE FOR THIS CONDITION? ☐ YES ☐ NO	DATE OF X-RAY	WHERE X-RAYS WERE DONE

4. PRIMARY CARE PHYSICIAN NAME AND ADDRESS	TELEPHONE # ( )

5. PHARMACY NAME	TELEPHONE # ( )

HOW DID YOU LEARN OF OUR PRACTICE?

ASSIGNMENT AND RELEASE:

AUTHORIZATION FOR RELEASE OF INFORMATION:
I authorize the release of any medical information to insurance carriers (including Medicare) concerning my treatment necessary to process this claim to Association of Specialty Physicians, Inc. I understand that any false claims, statements, documents or concealment of material fact, may be prosecuted under applicable federal and state laws.

AUTHORIZATION FOR ASSIGNMENT OF PAYMENTS:
I authorize payment of medical benefits to Association of Specialty Physicians, Inc. for services rendered to me. I understand that I am responsible for all charges, INCLUDING CO-PAYS AND CHARGES NOT COVERED BY INSURANCE.

I UNDERSTAND THAT REFERRAL FOR HMO PARTICIPANTS ARE THE PARTICIPANT'S RESPONSIBILITY. IF NO AUTHORIZATION WAS APPROVED PRIOR TO SERVICE, I ACCEPT FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED. THIS PAYMENT WILL BE DUE AT TIME OF SERVICE.

If I have a liability claim for my medical services, such as auto, worker's compensation, accident, etc., I understand that I am ultimately liable for services rendered to me and I agree to pay directly to Association of Specialty Physicians, Inc. should my claim with the insurance carrier and/or policy holder be denied or challenged.

CONSENT TO TREATMENT:
I authorize treatments to myself, or as an authorized person of the patient, by Association of Specialty Physicians, Inc. including employees therein.

CONSENT TO CONTACT BY CELL PHONE OR TEXT:
I authorize Association of Specialty Physicians, Inc. or its agents to contact guarantor and/or patient by cell phone or text for purposes of notifying appointments, outstanding bills, test results, and other medical practice activities. I understand I can revoke this at any time in writing.

(X)_____ Date _____

(Signature of patient or authorized person)