



PATIENT INFORMATION

Name: _____
 Address: _____

 City, State: _____,
 Phone: _____ []Home []Work [X]Other
 Phone: _____ []Home []Work [X]Other

PATIENT EMPLOYMENT Student: Y / N
 []Employed []Retired []Unemployed [X]Other
 Employer: _____
 Phone: _____
 Address: _____

GUARANTOR

[]Same as Patient
 Name: _____
 Address: _____

 City, State: _____

PRIMARY INSURANCE

[]Same as Patient []Same as Guarantor []Other

Insured Party: _____
 Date of Birth: _____ Gender: M / F
 Insured Phone: _____
 Company: _____

SECONDARY INSURANCE

[]Same as Patient []Same as Guarantor []Other

Insured Party: _____
 Date of Birth: _____ Gender: M / F
 Insured Phone: _____
 Company: _____

If Medicare is secondary, please specify the reason:

- Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan Other, please specify _____
 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan _____

I have completed this form accurately to the best of my knowledge and certify that I am the above-named patient or the duly authorized general agent of the above-named patient, authorized to furnish the information requested, and seek and authorize health care services. I understand that, even though I may have insurance coverage, I am responsible for payment for all services rendered. I authorize the release of any medical information necessary to process my insurance claim. I also request payment of all insurance medical benefits to Moscow Family Medicine, PA for services provided to the above-named person.

If I have Medicare or if, in the future, I seek services to be paid under the auspices of the Medicare program, I request that payment of authorized Medicare benefits be made either to me on my behalf or to Moscow Family Medicine, PA for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or these benefits payable to related services. I understand that my signature requests that payment be made, and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Doctor: _____

Patient ID #: 119221 Gender: []M []F
 Date of Birth: _____
 Social Security #: _____
 Marital Status: []Married []Single []Divorced
 Email Address: _____
 Primary Physician: _____

CONTACTS Name, Relationship to Patient & Phone #

EMPLOYMENT

Employer: _____
 Phone: _____
 Phone: _____
 Social Security #: _____
 Date of Birth: _____

Relationship to Primary Insured/Guarantor: _____
 Social Security #: _____
 Insured ID: _____
 Policy Group: _____

Relationship to Primary Insured/Guarantor: _____
 Social Security #: _____
 Insured ID: _____
 Policy Group: _____