Moscow Family Medicine

Patient Information Form

PATIENT INFORMATION

Doctor:

Name:
Address:

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

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

PATIENT EMPLOYMENT

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

CONTACTS

Name, Relationship to Patient & Phone #

GUARANTOR

[ ]Same as Patient
Name:
Address:

City,State:

EMPLOYMENT

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

PRIMARY INSURANCE

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

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

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

SECONDARY INSURANCE

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

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

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

If Medicare is secondary, please specify the reason:

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

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.

Signature (Responsible party if patient is a minor) Date

Print Date: **08/15/2011**