



Patient Information Form

C Patient Name: Last _____ First _____ MI _____

O Patient is a: UI Student Student's Spouse Student's Child

N Student's Name if different from patient: _____

T Student ID#: _____

Y **CONTACT INFORMATION:**

A Local Mailing Address: _____

O City, State: _____ Zip: _____

C Local Phone #: _____ Cell#: _____

U Patient's Date of Birth: _____ Sex: _____ Marital Status: S M W D

T Patient's Soc. Sec. #: _____ Spouse's Name: _____

I Patient's Permanent (Parent's) Address (if different from above):

N Street Address: _____

G City, State: _____ Zip: _____

I **Patient's Primary Insurance Plan:** SHIP Other (if other, please fill out info below)

N Name of Insurance Company: _____

S Insurance Co. Address: _____

U _____

I Policy or ID #: _____

R Group #: _____

N Family member's name who is the Policyholder: _____

A Policyholder's Date of Birth: _____ SSN#: _____ Sex: _____

F Policyholder's Address: _____

N City/State/Zip: _____

O Phone: _____

C Policyholder's Employer: _____

E

I authorize you to discuss my health status and care with the following parties. This authorization will continue in force until I revoke it in writing. I understand that information released in this manner may be subject to re-disclosure by the recipient.

Authorized Party	Relationship to Patient	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

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. 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 claims. I also request payment of medical benefits to Moscow Family Medicine, PA for services provided to the above-named patient. Further, I have been offered a copy of Moscow Family Medicine's Notice of Health Information Practices, which describes how my health information is used and shared. I understand that Moscow Family Medicine has the right to change this notice at any time. I may obtain a current copy by asking a receptionist or by visiting Moscow Family Medicine's web site at www.MoscowFamilyMedicine.com.

Signature

Date