PATIENT INFORMATION FORM

PATIENT INFORMATION (THE PERSON SEEING THE PHYSICIAN):

NAME_____
First M.I. Last

PHYSICAL ADDRESS_____CITY_____STATE_____ZIP_____
Street Address

MAILING ADDRESS_____CITY_____STATE_____ZIP_____
PO Box

PHONE(___)_____COUNTY_____

EMAIL_____MOBILE PHONE_____

SSN_____DATE OF BIRTH_____EMERGENCY NUMBER(____)_____

[ ] Male [ ] Female MARITAL STATUS: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

EMPLOYER_____PHONE(____)_____

ADDRESS_____CITY_____STATE_____ZIP_____

LENGTH OF EMPLOYMENT_____

SPOUSE NAME_____SSN_____DATE OF BIRTH_____

EMPLOYER_____

EMPLOYER ADDRESS_____CITY_____STATE_____ZIP_____

PHARMACY_____PHONE(____)_____

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? Y / N

MAY WE CALL YOU AT WORK? Y / N MAY WE LEAVE A MESSAGE WITH YOUR EMPLOYER Y / N

IS THE PATIENT A STUDENT? Y / N FULLTIME? Y / N

OTHER CONTACT (SOMEONE NOT LIVING IN THE HOME):

NAME_____
First M.I. Last

PHONE(____)_____RELATIONSHIP TO PATIENT_____

PARENT or GUARDIAN (REQUIRED IF PATIENT IN UNDER THE AGE OF 17) :

NAME_____
First M.I. Last

PHYSICAL ADDRESS_____CITY_____STATE_____ZIP_____
Street Address

MAILING ADDRESS_____CITY_____STATE_____ZIP_____
PO Box

EMAIL_____MOBILE PHONE_____

PHONE(___)_____SSN_____DATE OF BIRTH_____

COUNTY_____RELATIONSHIP TO PATIENT_____

PRIMARY INSURANCE

(MUST HAVE COPY OF CARD):

INSURED NAME_____
First M.I. Last

ADDRESS_____
(Physical—Insurance Requirement)

CITY_____STATE_____ZIP_____

PHONE(___)_____ [ ] M [ ] F

RELATIONSHIP TO PATIENT
[ ] Self [ ] Spouse [ ] Parent [ ] Other_____

SSN_____DOB_____

EMPLOYER_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE(___)_____LENGTH OF EMPLYMENT_____

INSURANCE NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE(___)_____

GROUP NUMBER_____

POLICY/ID NUMBER_____

EFFECTIVE DATE OF INSURANCE_____

HOSPITAL REQUIRED BY YOUR INSURANCE?

_____

PRIMARY CARE PHYSICIAN_____

REFERRING PHYSICIAN_____

DOES THIS INSURANCE REQUIRE A REFERRAL? Y / N

SECONDARY INSURANCE

(MUST HAVE COPY OF CARD):

INSURED NAME_____
First M.I. Last

ADDRESS_____
(Physical—Insurance Requirement)

CITY_____STATE_____ZIP_____

PHONE(___)_____ [ ] M [ ] F

RELATIONSHIP TO PATIENT
[ ] Self [ ] Spouse [ ] Parent [ ] Other_____

SSN_____DOB_____

EMPLOYER_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE(___)_____LENGTH OF EMPLYMENT_____

INSURANCE NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE(___)_____

GROUP NUMBER_____

POLICY/ID NUMBER_____

EFFECTIVE DATE OF INSURANCE_____

HOSPITAL REQUIRED BY YOUR INSURANCE?

_____

PRIMARY CARE PHYSICIAN_____

REFERRING PHYSICIAN_____

DOES THIS INSURANCE REQUIRE A REFERRAL? Y / N

As a courtesy, NEA Clinic will file your primary and secondary insurance. However, we are unable to process your insurance claims unless all information has been provided by you the patient. If all information is not provided you will be responsible for the remaining balance.

Payment is expected at the time of service. All deductibles, co-insurance and co-pays will be collected in full.

ASSIGNMENT OF BENEFITS AND RELEASE OF RELATED MEDICAL RECORDS

I hereby assign, transfer, and set over to NEA Clinic all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of my medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____ _____
Signature (Parent or Guardian, if patient is a minor) Date

How did you hear about NEA Clinic? ____Yellow Pages ____Newspaper _____Radio
_____TV ____Billboard ____Friends/Family ____Physician Referred _____Other