Today's Date: ______________________

Patient Name: ____ **Date of Birth**: ___________________

Social Security #: ____

Sex: □ Female □ Male **Marital Status**: □ Single □ Married/Civil Union □ Divorced □ Widowed

Address: ____

Street City State ZIP

Home Phone: _______________________ **Work**: _________________________ **Cell**: _______________________

E-mail (We will not share it or use it without your permission.):_____________________________________

Preferred method for appointment reminders: □ Home phone □ Cell phone □ E-mail

Preferred contact method for emergencies (e.g., office closing): □ Home phone □ Cell phone □ E-mail

Employer: ____

Emergency Contact: ____

Name Phone Number Relationship

Race: (We *are* required to ask. You are *not* required to answer. This is used to gather statistics about disparities in medical care by race, for example.)

□ African-American/Black

□ Asian*

□ Hispanic/Latino*

□ Native American/Alaskan*

□ Native Hawaiian/Pacific Islander*

□ White

□ Other

□ Decline to answer

***Ethnic Group:**____

(Native American tribe, Asian country, for example.)

INSURANCE INFORMATION:

Primary Insurance Company: ____

Insured's Name: ________________________________ **Insured's Date of Birth**: __________

Insured's Employer: _____________________________ **Social Security** #: _______________

Membership ID #: ______________________________ **Group** # ________________________

Patient Relationship to Insured: ____Self ____Spouse ____Child ____Partner ____Other

****

Secondary Insurance Company: ____

Insured's Name: _______________________________ **Insured's Date of Birth**: ___________

Insured's Employer: ____________________________ **Social Security** #: ________________

Membership ID #: _____________________________ **Group #**: ________________________

Patient Relationship to Insured: ____Self ____Spouse ____Child ____Partner ____Other

****

Tertiary Insurance Company: ____

Insured's Name: _______________________________ **Insured's Date of Birth**: ___________

Insured's Employer: ____________________________ **Social Security** #: ________________

Membership ID #: _____________________________ **Group** #: ________________________

Patient Relationship to Insured: ____Self ____Spouse ____Child ____Partner ____Other

Signature on File and Release of Information for Assignment of Benefits

PATIENT NAME: _____________________________ DATE OF BIRTH: ____________________

Dear Patient/Guarantor:

If you wish our office to be of service in billing your insurance company(ies) for you, we need your signature on the following statement.

Should we not receive this signed authorization, we cannot bill your insurance company(ies) for you. You will be responsible to us for your bill and you will have to bill your insurance company(ies) directly.

*** I authorize *Stony Creek Internal Medicine* to release medical information, including AIDS or alcohol-related information, or any information pertaining to the examination, treatment, history and medical expenses to my insurance company(ies)** for the purpose**
of processing insurance claims. This release may include the reviewing and/or photocopying pertinent documents for purposes of payment by my insurance carrier.

I authorize payment of medical insurance benefits* to be made directly to *Stony Creek Internal Medicine*. I permit a copy of this authorization to be used in place of the original.**

I further agree to accept full financial responsibility for payment of charges rendered to me/the above named patient.

Signature: ____ Date: __________________

IF GUARANTOR, RELATIONSHIP TO PATIENT: ___________________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signature:____Date:______________________________

If Guarantor, Relationship to Patient:____