



Name _____ Home # _____

Address _____ Sex (circle) Male/Female

City/State/Zip _____

Social Security # _____ Date of Birth _____

Place of Employment _____

Address _____

City/State/Zip _____

Position Held _____

Marital Status _____ Spouse/Parent's name _____

Medical Doctor's Name _____ Phone # _____

NAME OF NEAREST RELATIVE OR FRIEND (LOCALLY) NOT LIVING WITH YOU _____

Phone # _____ Relationship to you _____

To our patients: State regulations require us to collect the following racial information for statistical purposes. Please choose a selection from the choices below. (If you do not wish to disclose this information please select "No Response")

Asian African American Hispanic Non-Caucasian Hispanic

Caucasian Native American Other No Response

Copy of Patient Bill of Rights Received/Financial Policy (please initial) _____

Primary Insurance _____ Secondary Insurance _____

Insurance benefits we quote are based on the information given by your insurance company prior to your visit. The patient amount due on the date of service may change once your insurance company processes the claim and provides us with written notice of the patient responsibility. If there is any remaining patient responsibility you will be billed and responsible for that balance.

Medicare Secondary Payer Screening

- 1) Are you currently receiving Medicare Benefits? YES NO (if "YES", please answer questions 2,3, & 4)
- 2) Are either you or your spouse currently working? YES NO
- 3) Are either you or your spouse currently provided with any group health coverage? YES NO
- 4) Are you currently receiving any other health care benefits (i.e. Black Lung, Veterans Affairs, Government research program grant, work, non-work or automobile related injury or illness benefits? YES NO

Advanced Directives

- 1) YES, I DO NO I DO NOT have an Advanced Directive, Living Will, or Health Care Power of Attorney. (If YES, then another form will be provided for your review and acknowledgement.)
- 2) YES, I DO NO I DO NOT want to have information on Advanced Directives. (If YES, then a brochure will be made available to you for your review.)

I have reviewed and agree with the above.

SIGNATURE OF RESPONSIBLE PARTY

DATE

WITNESS

DATE