

PATIENT INFORMATION FORM

PATIENT INFORMATION:

NAME: LAST		FIRST	MIDDLE NAME	SEX <input type="checkbox"/> M <input type="checkbox"/> F		BIRTH DATE	AGE
ADDRESS: STREET			CITY	STATE	ZIP	HOME PHONE: CELL PHONE:	
MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W		SOCIAL SECURITY #	OCCUPATION	EMPLOYER PHONE ()		IF STUDENT	
EMPLOYER OR NAME OF SCHOOL			ADDRESS	STATE	ZIP CODE		

SPOUSE, PARENT OR GUARDIAN INFORMATION:

NAME: LAST		FIRST	MIDDLE NAME	SEX <input type="checkbox"/> M <input type="checkbox"/> F		BIRTH DATE	AGE
ADDRESS: STREET			CITY	STATE	ZIP	TELEPHONE # ()	
		SOCIAL SECURITY #	EMPLOYER OR SCHOOL NAME AND ADDRESS				

INSURANCE INFORMATION:

*** PLEASE SHOW CARDS TO RECEPTIONIST ***

IF AUTOMOBILE, JOB INJURY OR ACCIDENT, LIST RESPONSIBLE PARTY OR INSURANCE AS PRIMARY AND HEALTH INSURANCE AS SECONDARY.

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY

ADDRESS:			TELEPHONE # ()			
WHO OWNS THE POLICY?		BIRTH DATE	SOCIAL SECURITY #			
ID # OR AGREEMENT #	GROUP #	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER				
EFFECTIVE DATE	EMPLOYER OF INSURANCE CARRIER					

SECOND OR CO-INSURANCE

NAME OF INSURANCE COMPANY

ADDRESS:			TELEPHONE # ()			
WHO OWNS THE POLICY?		BIRTH DATE	SOCIAL SECURITY #			
ID # OR AGREEMENT #	GROUP #	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER				
EFFECTIVE DATE	EMPLOYER OF INSURANCE CARRIER					

ASSIGNMENT AND RELEASE:

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information to insurance carriers (including Medicare) concerning my treatment necessary to process this claim to Association of Specialty Physicians, Inc. I understand that any false claims, statements, documents or concealment of material fact, may be prosecuted under applicable federal and state laws.

AUTHORIZATION FOR ASSIGNMENT OF PAYMENTS:

I authorize payment of medical benefits to Association of Specialty Physicians, Inc. for services rendered to me. I understand that I am responsible for all charges, INCLUDING CO-PAYS AND CHARGES NOT COVERED BY INSURANCE.

I UNDERSTAND THAT REFERRAL FOR HMO PARTICIPANTS ARE THE PARTICIPANT'S RESPONSIBILITY. IF NO AUTHORIZATION WAS APPROVED PRIOR TO SERVICE, I ACCEPT FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED. THIS PAYMENT WILL BE DUE AT TIME OF SERVICE.

If I have a liability claim for my medical services, such as auto, worker's compensation, accident, etc., I understand that I am ultimately liable for services rendered to me and I agree to pay directly to Association of Specialty Physicians, Inc. should my claim with the insurance carrier and/or policy holder be denied or challenged.

CONSENT TO TREATMENT:

I authorize treatments to myself, or as an authorized person of the patient, by Association of Specialty Physicians, Inc. including employees therein.

(X) _____
(Signature of patient or authorized person)

Date _____ (OVER)

HEALTH QUESTIONS

PATIENT NAME _____

1. BRIEFLY DESCRIBE WHY YOU ARE VISITING OUR OFFICE:

2. IF CONDITION IS DUE TO AN ACCIDENT, PLEASE DESCRIBE NATURE OF ACCIDENT:

DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY
DATE OF DISABILITY		RETURN TO WORK DATE
3. DID YOU HAVE X-RAYS DONE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF X-RAY
		WHERE X-RAYS WERE DONE

(BRING X-RAY FILMS AT THE TIME OF YOUR VISIT)

4. PRIMARY CARE PHYSICIAN NAME AND ADDRESS	TELEPHONE # ()
5. PHARMACY NAME	TELEPHONE # ()
6. NAME AND ADDRESS TO CONTACT FOR EMERGENCY	TELEPHONE # ()

HOW DID YOU LEARN OF OUR PRACTICE? (PLEASE CHECK ALL THAT APPLY)

- | | |
|---|--|
| <input type="checkbox"/> PHYSICIAN REFERRED | <input type="checkbox"/> YELLOW PAGES |
| <input type="checkbox"/> THE MEDICAL CENTER, BEAVER | <input type="checkbox"/> SCHOOL PROGRAM |
| <input type="checkbox"/> ALIQUIPPA HOSPITAL | <input type="checkbox"/> WHICH ONE? _____ |
| <input type="checkbox"/> EMERGENCY ROOM, MED. CTR. | <input type="checkbox"/> WORKER'S COMPENSATION PANEL |
| <input type="checkbox"/> EMERGENCY ROOM, ALIQUIPPA | <input type="checkbox"/> EMPLOYER _____ |
| <input type="checkbox"/> WORD OF MOUTH | <input type="checkbox"/> OTHER _____ |
| FROM WHOM? _____ | _____ |
| <input type="checkbox"/> FRIEND | _____ |
| NAME _____ | |
| <input type="checkbox"/> RELATIVE | |
| NAME _____ | |
| <input type="checkbox"/> BEAVER COUNTY TIMES | |