

ESTES PARK MSO PATIENT INFORMATION FORM

PATIENT INFORMATION Today's Date _____

Last Name: _____ First Name _____ M.I. _____
Address: _____ Home Phone # _____ City: _____
City _____ State _____ Zip _____ Work Phone # _____

Check here if you have a different address for part of the year and complete alternate address below:

Address: _____ Home Phone # _____ City: _____
City _____ State _____ Zip _____

Dates @ this address: _____

Gender: FEMALE MALE MARITAL STATUS: Single Married Other _____

DATE OF BIRTH: _____

SSN: _____ Race: Caucasian, Hispanic, Black, Other _____

(This information is now required by Federal Government/Insurance to process claims)

Date of Injury: _____ EMPLOYER: _____

EMERGENCY CONTACT NAME & PH#: _____

Name of Referring Physician: _____

****REQUIRED INFORMATION** Insured Party Information (NAME OF PERSON INSURANCE IS THROUGH)**

(If this information is not complete and accurate we cannot process your claim and you will be responsible for your bill)

Name: _____ Home Phone # _____

Address: _____ EMPLOYER: _____

City: _____ State: _____ Zip: _____ SSN: _____

Date of Birth: _____ Race: Caucasian, Hispanic, Black, Other _____

(This information is now required by Federal Government/Insurance to process claims)

Relationship to patient: Self Wife Husband Parent Legal Guardian Other _____

If you do not accurately complete the Insurance Section (s) we will assume you have no insurance and charges may be due at time of service. Insurance Information PLEASE PRESENT COPY OF CARD EACH VISIT!

Effective date _____

Insurance Co. Name: _____ ID # _____

Claims Address: _____ Group # _____

City: _____ State: _____ Zip: _____ Phone# _____

SECONDARY INSURANCE INFORMATION: PLEASE PRESENT COPY OF CARD EACH VISIT!

Effective date _____

Insurance Co. Name: _____ ID # _____

Claims Address: _____ Group # _____

City: _____ State: _____ Zip: _____ Phone# _____

- I consent to medical treatment.
- I authorize the release of medical information relating to my care to my insurance company as well as to physicians and other health care providers involved in my care. This includes medical information requested by my insurance for billing purposes, utilization review and quality assurance.
- I authorize insurance payments to be made directly to my physician for the medical and/or surgical care provided under my insurance agreement and otherwise payable to me.
- I agree to pay my co-payment at the time of service. I also agree to pay any amounts that may not be paid by my insurance.
- If I am uninsured, I agree to pay for all charges at the time of service, unless other arrangements have been made.
- If the patient is a minor, I give permission for him or her to be treated by the physicians at the Family Medical Clinic.
- I agree that medical and para-medical students may observe and be involved in the medical care provided.

Responsible Party Signature _____ **Date** _____

MEDICARE BENEFICIARIES ONLY:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Family Medical Clinic physicians for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature _____ **Date** _____

Please tell us why you've chosen our office. Check all that apply.

- Recommendation by friend, relative, or colleague;
- Convenient location;
- Convenient office hours;
- Other _____

Thank you for choosing the Family Medical Clinic for your health care needs.