

Patient Information Form

PATIENT NAME: _____ SEX: _____ BIRTHDATE: _____ AGE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

TELEPHONE: (HOME) _____ (WORK) _____ SS NUMBER: _____

NEAREST RELATIVE (Not living with you) AND TELEPHONE #: _____

EMPLOYER: _____ EMPLOYER TELEPHONE: _____

EMPLOYER'S ADDRESS: _____ MARITAL STATUS: _____

HOW DID YOU HEAR ABOUT US? _____

WHAT IS THE PROBLEM YOU ARE HAVING TODAY? _____

INSURANCE INFORMATION

Please give the receptionist your insurance card(s) to photocopy

PRIVATE INSURANCE: NAME OF COMPANY: _____

ADDRESS: _____ TELEPHONE: _____

SUBSCRIBER: _____ SUBSCRIBER BIRTHDATE: _____

SUBSCRIBER ADDRESS: _____ SUBSCRIBER PHONE: _____

SUBSCRIBER'S EMPLOYER: _____ EMPLOYER PHONE: _____

POLICY NO. _____ GROUP NO. _____ RELATION TO PATIENT: _____

WORKER'S COMPENSATION: WC CARRIER: _____

CLAIM NO. _____ DATE OF INJURY: _____ SUPERVISOR: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____

AUTO ACCIDENT: INSURANCE COMPANY: _____ AGENT: _____

ADDRESS: _____ PHONE: _____

INSURED'S NAME: _____ POLICY NO.: _____

STATE IN WHICH ACCIDENT OCCURRED: _____ DATE OF ACCIDENT: _____

SIGNATURE on back of form required before treatment can be administered. Please read carefully before signing.

SIGNATURE ON FILE

I authorize the use of this form on all my insurance submissions.

I authorize release of medical information to all of my insurance companies.

I understand that I am responsible for all fee's regardless of my insurance coverage.

I understand that there may be services that are provided to me by Dr. Aitken that are not covered by my insurance carrier and I agree to be financially responsible for such services.

I understand that all fee's are to be paid at the time of service unless prior financial arrangements have been made with the Office Manager.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance carrier's.

I authorize payment directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

Name (Please Print) _____

Signature _____ Date _____

PATIENT'S MEDICARE AUTHORIZATION

Patient's Name _____

Patient's Medicare No. _____

I request that payment of authorized Medicare Benefits be made on my behalf to George K. Aitken, M.D., PSC, for any services furnished by Dr. Aitken. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine benefits payable for services rendered. I understand my signature requests that payment be made to Dr. Aitken for services rendered and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, George K. Aitken, M.D., PSC, agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature _____ Date _____