

Patient Information Form

Section I – Patient Information

Name:

(Please print full legal name – no nicknames)

Address:

City: _____ State: _____ Zip code: _____

Home number: () _____ - _____ Mobile number: () _____ - _____

Email address: _____ @ _____

SSN: _____ - _____ - _____ Date of Birth ____ / ____ / ____

Gender: Male Female Martial Status: Single Married Widowed Divorced
(please circle one) (please circle one)

Race: _____ White (non Hispanic) _____ Hispanic _____ Asian
_____ American Indian _____ Indian _____ African American
_____ Other _____

Employer: _____

Occupation: _____ Work number: () _____ - _____

Primary Language: _____

PCP: _____

Section II- Insurance

For medical record purposes, please present all current insurance cards to Front Desk for verification and scanning.

Are you covered by more than one carrier? YES NO

Primary Policy Name: _____

Group Number: _____ Policy Number: _____

Secondary Policy Name: _____
Group Number: _____ Policy Number: _____
Name of Primary insured if other than yourself: _____
Insurance holder's date of birth: ____ / ____ / ____ Insurance holder's SSN ----- _____

Section III – Authorizations

Do you give permission for our office to discuss your medical information with others? Yes
or No

If yes, then tell us with whom: Name _____

Relationship _____ phone # _____

Emergency contact name: _____

Relationship _____

Phone Number: _____

Email: _____

May we leave personal medical information on your answering machine or cell phone? Yes No

How would you like to be addressed from the waiting room? (Please circle all that apply)

Full Name Last Name Only First Name

How may this office contact you in regards to appointments, treatment, billing? (Please circle all that apply)

Cell Phone Home Phone Work Phone Email Text All methods

How may this office convey your medical information to you? (Please circle all that apply)

Cell Phone Home Phone Work Phone Email Text All methods

Section IV – Office Policy

Financial- It is the policy of this office to collect all co payments due at the time of service. If a balance is due on your account, we will send you a statement for that balance. A total of only 2 statements will be sent. If no payment is received after the second notice, your account may be placed with an outside collection agency for settlement.

Appointments- This office is operated on an **appointment basis**. If you are more than 15 minutes late for your scheduled appointment, we as that you reschedule as a courtesy to others. For sit If you need to cancel an appointment, please call as soon as possible to let us know. Patients who **continually** do not show for their scheduled appointments without calling to cancel, will be asked to find care from another provider. You will be sent a certified letter informing you of this decision. There is a \$50.00 charge for all no show, no call appointments per occurrence.

HIPPA - We will protect your right to privacy as outlined by HIPPA laws. Brochures are available throughout this office for your convenience. By signing below, you agree that you understand your rights under this policy.

Assignments- You agree to have all insurance payments sent directly to the doctor performing your service(s). We will file all charges as a courtesy for you to your carrier. There are times when medical information will be requested by your carrier in order to verify and process your charge(s). By signing below, you grant us the right to send this information on your behalf so that your charges may be settled.

Consent for Tx: I authorize medical treatment from Bethesda Medical Clinic, L.L.C. and its staff for conditions presented to by myself or those who have medical power of attorney over me.

Patient Signature of Agreement

____ / ____ / ____

Date