PATIENT INFORMATION

PATIENT INFORMATION: DATE: _____

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____STATE:_____ ZIP:_____

HOME PHONE:_____ CELL #: _____ WORK #:_____

SOCIAL SECURITY #: _____ MARITAL STATUS: M S W D

WHOM MAY WE CONTACT IN CASE OF EMERGENCY? _____ RELATIONSHIP:_____

RACE: _____ LANGUAGE: _____ ETHNICITY: _____

May we leave a message on your answering machine? YES NO

May we speak to your spouse or adult child about your condition (or another person)? YES NO

Name of Person(s) _____ Phone #: _____

Name of Person(s) _____ Phone #: _____

ALLERGIES TO MEDICATIONS: _____

PATIENT EMPLOYER INFORMATION:

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE #: _____ OCCUPATION: _____

SPOUSE'S / SIGNIFICANT OTHER INFORMATION:

SPOUSE'S / SIGNIFICANT OTHER NAME: _____ DATE OF BIRTH: _____

EMPLOYER NAME & ADDRESS: _____

_____ EMPLOYER'S PHONE #: _____

INSURANCE INFORMATION: **PRESCRIPTION PLAN: YES NO**

NAME OF **PRIMARY** INSURANCE: _____ COPAY AMOUNT: _____

ADDRESS: _____ PHONE #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DOB: _____

INSURANCE ID #: _____ GROUP #: _____

NAME OF **SECONDARY** INSURANCE: _____ COPAY AMOUNT: _____

ADDRESS: _____ PHONE #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DOB: _____

INSURANCE ID #: _____ GROUP #: _____

PATIENT INFORMATION

RESPONSBILITY PARTY:

PLEASE COMPLETE THE SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE BILL:

NAME: _____ ADDRESS:_____

PHONE #: _____ RELATIONSHIP TO PATIENT:_____

EMPLOYER NAME & ADDRESS: _____

EMPLOYER PHONE #: _____

The signature, below, authorizes the release of any medical information necessary to process any claims submitted. I, also, request payment of benefits be made to Lehigh Area Medical Associates, PC, for any services rendered to me by any or all LAMA providers.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. This includes co-insurance, non-covered services, "less amounts that exceed maximum coverage", copayments, deductibles, etc.

Payment of office visit(s) due at the time of service, except for Medicare patients and for those insurances with which this office has a contractual agreement**. CO-PAYS ARE DUE AT THE TIME OF SERVICE**.

I authorize any holder of medical information about me to release to my current medical insurance company, including Centers of Medicare and Medicaid Services or its agents, any information needed to determine these benefits or the benefits payable for related services of the HIC/Policy Number written on this form. In addition, I request that payments of authorized Medicare or my insurance benefits be made/assigned on my behalf to Lehigh Area Medical Associates, PC, for any services rendered to me by any LAMA providers.

FOR MEDICARE PATIENTS ONLY: I request the payments of Medigap Benefits (secondary co-insurance) as noted on this form, be made to Lehigh Area Medical Associates, PC, for any service rendered to me by any LAMA providers.

I have read all of the information and I certify that this information is true and correct to the best of my knowledge. I will notify your office of any changes in the above information.

PATIENT SIGNATURE OR AUTORIZED PERSON: _____

DATE: _____/_____/_____ (Completion of the Form and Signature Required)

I have reviewed my Patient Information Sheet and agree that there are no changes from the previous year.

Signature:_____ Date:_____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____