

THE PHYSICIAN & MIDWIFE COLLABORATIVE PRACTICE

Please **COMPLETELY** fill out all applicable information & return this form to the front desk

Patient Demographics

Patient Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Home: _____
Work: _____
Cell: _____

Date of Birth: _____
Social Security#: _____
Driver's License#: _____
Race: _____ Religion: _____
Employer: _____
Employer Address: _____

May we contact you about your confidential health information by e-mail?: Yes No

Spouse's Name: _____
E-mail Address: _____

Is it okay to leave messages on: (Please circle all that apply) Home Work Cell

Marital Status: (Please Circle) Single Married Widowed Separated Divorced

Patient Insurance Information

Primary Insurance: _____
Claims Address: _____

ID#: _____
Group#: _____
Subscriber's Name: _____
Subscriber's Relation: _____
Subscriber's DOB: _____
Subscriber's SS#: _____
Subscriber's Address: _____

Subscriber's Daytime Phone#: _____
Subscriber's Employer: _____

Secondary Insurance: _____
Claims Address: _____

ID#: _____
Group#: _____
Subscriber's Name: _____
Subscriber's Relation: _____
Subscriber's DOB: _____
Subscriber's SS#: _____
Subscriber's Address: _____

Subscriber's Daytime Phone: # _____
Subscriber's Employer: _____

Emergency Contact & Consent to Share Information

Emergency Contact: _____ Relation: _____ Phone#: _____

Is there anyone you give permission to share your private health information with: If so, please list below:

Name: _____ Relation: _____ Phone#: _____
Name: _____ Relation: _____ Phone#: _____

AUTHORIZATION

I hereby authorize the release of all medical information necessary for the processing of insurance claims. I also authorize my insurance company to make payments directly to "The Physician and Midwife Collaborative Practice".
I understand I am responsible for payment denied by my insurance due to lack of referral and/or inaccurate insurance information.
I understand that I am responsible for obtaining referrals prior to my appointment.
I understand that I am responsible for the payment of any portion of my bill not paid by my insurance company. I also understand that if my account is turned over for collection a \$25 fee will be assessed to my account. This fee is non-negotiable. **(Accounts are not turned over for collection without notification to the patients or clients). I understand that if my account is turned over for collections I will not be able to make any future appointments until the debt is paid in full".**

(Please sign only once per visit)

Patient Signature: _____ Date: _____
Patient Signature: _____ Date: _____
Patient Signature: _____ Date: _____