GRAPEVINE INTERNAL MEDICINE CENTRE

Welcome To Our Office

PATIENT INFORMATION

PATIENT'S NAME (PLEASE PRINT)	SS#	BIRTHDATE	
	MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP	SEX ☐M ☐F	AGE
STREET ADDRESS ☐PERMANENT ☐TEMPORARY	CITY, STATE, ZIP	DAYTIME PHONE	☐CELL ☐HOME ☐WORK
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	ALTERNATE PHONE	☐CELL ☐HOME ☐WORK
EMPLOYERS STREET ADDRESS	CITY, STATE, ZIP	ALTERNATE PHONE	☐CELL ☐HOME ☐WORK
DRUG ALLERGIES, IF ANY			
SPOUSE OR PARENT'S NAME	SS#	BIRTHDATE	
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	DAYTIME PHONE	☐CELL ☐HOME ☐WORK
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP	ALTERNATE PHONE	☐CELL ☐HOME ☐WORK
SPOUSE'S STREET ADDRESS, IF DIFFERENT THAN ABOVE	CITY, STATE, ZIP	ALTERNATE PHONE	☐CELL ☐HOME ☐WORK

PLEASE READ:

All charges are due at the time of services. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization.

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	RELATIONSHIP TO PATIENT	DAYTIME PHONE	☐CELL ☐HOME ☐WORK
STREET ADDRESS ☐PERMANENT ☐TEMPORARY	CITY, STATE, ZIP	ALTERNATE PHONE	☐CELL ☐HOME ☐WORK
WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? ☐YES ☐NO	IF YES, WHERE WERE X-RAYS TAKEN? (HOSPITAL, ETC.)	DATE X-RAYS TAKEN	
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? INCLUDE NAME OF PHYSICIAN AND FAMILY MEMBER			
REFERRED BY	STREET ADDRESS, CITY , STATE, ZIP	DAYTIME PHONE	☐CELL ☐HOME ☐WORK

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH YOUR BOOKKEEPER.

YOU MAY RECEIVE A BILL FROM AN INDEPENDENT LAB IN SOME CASES. _____ PLEASE INITIAL WHEN READ.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder _____

I request that payment of authorized Medicare/Other insurance company benefits be made to me on my behalf to _____ for any services furnished me by that party who accepts assignment physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of CMS-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other insurance company.

Signature _____ Date _____