VERNOSE MCGRATH ASLANIDIS

PATIENT INFORMATION FORM

WELCOME TO OUR OFFICE!

IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.
ALL INFORMATION WILL BE STRICTLY CONFIDENTIAL (*PLEASE PRINT CLEARLY)*

PATIENT'S NAME (*PLEASE PRINT)* | **SOCIAL SEC. NUMBER** | **BIRTHDATE / /** | **SEX M / F** | **AGE**

STREET ADDRESS | **MARITAL STATUS S / M / W / D / SEP.** | **CELL PHONE** | **HOME PHONE**

CITY | **STATE** | **ZIP CODE** | **EMAIL ADDRESS**

PATIENT'S EMPLOYER | **OCCUPATION (Indicate if Student)** | **BUSINESS PHONE**

EMPLOYER STREET ADDRESS

CITY | **STATE** | **ZIP CODE**

SPOUSE OR PARENTS NAME | **SOCIAL SEC. NUMBER** | **BIRTHDATE**

SPOUSE OR PARENTS EMPLOYER | **OCCUPATION**

REFERRED BY (PHYSICIAN, INDIVIDUAL, HOSPITAL, OTHER)

FAMILY PHYSICIAN | **ADDRESS** | **CITY & STATE** | **ZIP CODE** | **TELEPHONE**

PHARMACY NAME | **ADDRESS** | **CITY & STATE** | **ZIP CODE** | **TELEPHONE**

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/ other insurance company benefits be made either to me or on my behalf to _____ for any service furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize my holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/ other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefit, either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding information.)

I am responsible for all deductibles, co-insurance, co-pays and non-covered services.

SIGNATURE: _____ DATE: _____