CONFIDENTIAL DATA

INDIANA INTERNAL MEDICINE CONSULTANTS – INDIANA PRIMARY CARE ASSOCIATES
CENTER FOR RESPIRATORY & SLEEP MEDICINE – INDIANA INFECTIOUS DISEASE CONSULTANTS

Date _____Patient's Date of Birth _____ Patient's Social Security Number _____

Patient Name _____
Last First Middle

Home Address _____
Street City State Zip Code

Home Phone # _____ Cell Phone # _____ Other Phone # _____

E-mail address _____ May we contact you by e-mail? □ Yes □ No

Patient Sex □ Male □ Female **Relationship Status**: □ Married □ Single □ Widowed □ Divorced □ Partnered □ Other

Referring Physician _____
(First) (Last)
Address _____

Phone # _____

Family Physician _____
(First) (Last)
Address _____

Phone # _____

Name of Employer _____ Employer Phone _____

Name of Spouse/Partner _____Spouse/Partner Work #_____Spouse/Partner Cell# _____

Name & phone number of nearest relative not living with you: Name_____ Phone#_____

IN ORDER FOR US TO FILE WITH YOUR INSURANCE COMPANY, ALL INFORMATION IN THIS SECTION MUST BE COMPLETE & ACCURATE. YOU MUST FILL THIS OUT EVEN THOUGH YOUR INSURANCE CARD HAS BEEN COPIED.

INSURANCE INFORMATION

Primary Insurance _____

Policy Holder _____
□ Male □ Female

Relationship _____

DOB _____

Employer _____

Secondary Insurance _____

Policy Holder _____
□ Male □ Female

Relationship _____

DOB _____

Employer _____

ANCILLARY SERVICES INFORMATION

If your insurance requires you to go to a specific location for labs or X-rays, what is the name of that location?

Labs drawn in our office may be sent to Mid America Clinical Labs, University of Missouri, or Southbend Medical Foundation Lab if we are unable to do the processing in our lab)

Please note: This information is requested for your protection, incorrect information supplied could result in your insurance not paying for services, leaving you responsible for the balance. If you are unsure of any information, we can make a telephone available for you to retrieve information. If you have any questions, please feel free to ask the receptionist.

RELEASE OF INFORMATION

I hereby authorize insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services or items processed as patient responsibility per the insurance. I also authorize the physician to release information required to process claims and agree that a photocopy of this authorization is as valid as the original. If for any reason you request your medical records to be sent to anyone, I.E. (yourself, physician, attorney, etc.) you **will** be charged a fee, unless **we** refer you to another physician.

Signature **Date**