PATIENT INFORMATION SHEET

Patient's Name ______________________________ Date of Birth ______________
Last First M I

Address ______________________________
Street City State Zip

Phone (________) ______________________ Cell # (________) ______________

If you are a Student provide your Parents First & Last name ______________________

Social Security No. ________-________-________ Marital Status ______________

Occupation ______________________ Drivers License# ______________

Employed by: ______________________ Work # (________) ______________

Employers Address ______________________________
Street City State Zip

Husband's Name ______________________ SS# ________-________-________

Employed by: ______________________ Work # (________) ______________

Husband's Date of Birth ______________ Husband's Cell # (________) ______________

Primary Language Spoken ______________________________

Name of Nearest Relative (Not living at same address) ______________ Relationship ________

Address ______________________________ Phone No. ________

Pharmacy Name and Phone # ______________________________

Who is your PCIP ______________________________

Insurance Relationship ❑ Self ❑ Spouse ❑ Child ❑ Other ______________

Insured Date of Birth ______________ Policy Holders Name ______________

Primary Insurance Company Name ______________________________

Address ______________________________
Street City State Zip

Group No. ____________ ID# ____________ Policy Holder's SS. # ____________

Secondary Insurance Company Name ______________________________

Address ______________________________
Street City State Zip

Group No. ____________ ID# ____________ Policy Holder ____________

I further acknowledge that should my account be forwarded to a collection agency or attorney because of non-payment, that I shall be responsible for anyfees associated with collecting of the unpaid portion of my bill.

______________________ Signature ______________ Date

PRIVATE INSURANCE CARRIERS CERTIFICATION OF PAYMENT

I hereby assign payment of all of my applicable basic health insurance benefits and major medical benefits directly to Michele Beck-Torres MD., P.A., and I further expressly understand that I am fully responsible for any and all charges that are not covered by this assignment. I hereby authorize for release of Medical Information necessary to process insurance claims by the physicians at the Michele Beck-Torres MD., P.A..

______________________ Signature ______________ Date

MEDICARE CERTIFICATION FOR PAYMENT

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I Authorize any holder of medical or other information about me to the Social Security Administration or its intermediaries or carriers any information deeded for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicate for payment to me. I further expressly understand that I am fully responsible for any and all charges that are not covered by these assignments.

______________________ Signature ______________ Date