# Welcome to Piedmont Internal Medicine!

**Date form completed: ________________**

## PATIENT INFORMATION

Patient Name: ______________________________ Home Phone: ( ) __________ Cell: ( ) __________

Address:______________________________________________ Preferred Language: ______________

Date of Birth: ______________________ Age: ________ Social Security #: ____________________

Sex (M/F) ______ Employed (Y/N) ________ Student (Y/N) _________ Marital Status:________________

Race: __ Asian __ Black __ Hispanic __ White __ Other: __________ Ethnic Group: (Optional) ________________

Employer Name: ____________________________ Work Phone: ( ) __________ Cell: ( ) __________

Employer Address: ______________________________________________________________

Emergency Contact Person: __________________________Emergency Phone #: ( )____________________

Patient's Primary Care Physician: ______________ Patient's Email address: ____________________________

## RESPONSIBLE PARTY INFORMATION

Policy Holder: ______________________________ Home Phone: ( ) ________Cell: ( ) ____________

Address: ______________________________________________________________________

Date of Birth: ____________________ Age: ________ Social Security #: ____________________

Sex (M/F) _______ Employed (Y/N) _______ Student (Y/N) ________ Marital Status:________________

Employer Name: ______________________________ Work Phone: ( ) ________ Cell: ________________

Employer Address: ______________________________________________________________

## INSURANCE INFORMATION

_______ Self-Insured
_______ Employer-Insured

_______ No Insurance
_______ Workers Comp
(Please complete #3 below)

1) ________________________ ________________________ ________________________
Insurance Company (Primary) Group # ID#

________________________ ________________________ ________________________
Policy Holder Name Policy Holder Employer Relationship to above patient

2) ________________________ ________________________ ________________________
Insurance Company (Secondary) Group # ID#

________________________ ________________________ ________________________
Policy Holder Name Policy Holder Employer Relationship to above patient

3) ________________________ ________________________ ________________________
Workers Comp. Ins. Who authorized your visit Date of accident

__________________________________________________ ( )____________________
Workers Comp. Address Workers Comp. Phone #

(over)

## Concerning Insurance

I hereby authorize this practice and its providers to apply for benefits on my behalf for covered services rendered.

I certify that the information I have submitted with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier (or, in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration). A copy of the authorization may be used in place of the original. This authorization may be revoked by either me or my insurance carrier at any time in writing.

## Assignment of Benefits

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this practice and its providers for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance company.

## For Medicare Patients Only

I understand that in certain circumstances Medicare may decide that appropriate medical services are not medically reasonable or necessary under the Medicare law. Since Medicare may deny payment for these services, I agree to be personally and fully responsible for payment of any denied charges.

## Authorizations

I hereby certify that the information provided on the reverse side is correct. I hereby certify that I have read and understand the above policies and agree to assume financial responsibility for services not covered by insurance. I further agree to pay finance charges and/or collection fees assessed to my account for any overdue balances.

I authorize this practice to leave messages regarding my medical appointments, conditions, test results, etc. with:

**List names:**

______________________________

______________________________

______________________________

**Messages may be left:**

| | | | |
|---|---|---|---|
| Answering machine | Y __ | N __ | N/A __ |
| Work number | Y __ | N __ | N/A __ |
| Cell number | Y __ | N __ | N/A __ |

X______________________________________
Signature of patient, insured, or beneficiary

______________________
Date

How did you learn of Piedmont Internal Medicine? Please check (✓) all that apply:

- ❑ Internet/Web Site
- ❑ Family/Friend: ____________________
- ❑ Newspaper/Magazine Ad
- ❑ Physician Referral: Dr. ____________________
- ❑ White Pages
- ❑ Other - please specify:

Please return completed form to the receptionist. Thank you.