

PATIENT INFORMATION FORM

NAME (last, first, middle): _____ TITLE: _____

HOME ADDRESS: _____

PREFERRED NAME: _____ SS# _____ - _____ - _____ DOB: ____/____/____

HOME PHONE: _____ CELL PHONE: _____ SEX: M ___ F ___

WORK PHONE: _____ EMAIL: _____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

Allergies: _____

I hereby authorize payment of medical benefits billed to my insurance to Faculty Internal Medicine; I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if Faculty Internal Medicine does not participate with my insurance.

I agree to pay all co payments, coinsurances, and deductibles at the time the services are rendered.

I will pay by (check one) Cash Check Credit Card

Signature of patient or guardian

Date