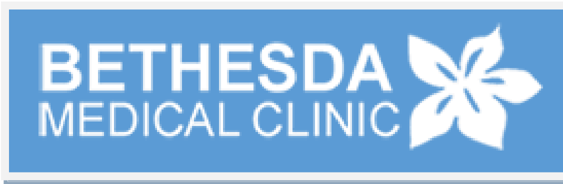

Patient Information Form

Section I – Patient Information

Name: ____

(Please print full legal name – no nicknames)

Address: ____

City: _______________ State: __________ Zip code: ___________

Home number: (   )______-________ Mobile number:(   )______-_________

Email address: __________________________@_______________

SSN: _____-_____-________ Date of Birth____/____/______

Gender: Male Female Martial Status: Single Married Widowed Divorced
(please circle one) (please circle one)

Race: ____ White (non Hispanic) _____Hispanic _____ Asian
____ American Indian _____ Indian _____ African American
____ Other _______________

Employer:_____________________________ Occupation:_________________________
Work number: (   ) ______-__________ Work Email: _____________________________

Primary Language: ___________________

*Please note that this office uses English as it primary language. We do not offer any interpreter or translation services. If you require an interpreter, you must provide one for yourself prior to medical treatment. *

Section II- Insurance

For medical record purposes, please present all current insurance cards to Front Desk for verification and scanning.

Are you covered by more than one carrier? YES NO
Primary Policy Name: ____
Group Number: ______________________ Policy Number: _______________________

Secondary Policy Name: ____
Group Number: ______________________ Policy Number: _______________________

Continued, please flip page over.

Third Policy Name: ____
Group Number: ______________________ **Policy Number:** ________________________
Name of Primary insured if other than yourself: ____________________________________
Insurance holder's date of birth: ____/____/_____**Insurance holder's SSN:** ____-____-______

Section III – Authorizations

Do you give permission for our office to discuss your medical information with others?
Yes or No
If yes, then tell us with whom:
Name __________________________ **Relationship** ____________**phone #**____________
Name __________________________ **Relationship** ____________**phone #**____________
Emergency contact name:_________________________ **Relationship**_________________
Phone Number: __________________ **Email:**_____________________________________

May we leave personal medical information on your answering machine or cell phone? Yes No
How would you like to be addressed from the waiting room? (Please circle all that apply)
Full Name Last Name Only First Name
How may this office contact you in regards to appointments, treatment, billing? (Please circle all that apply)
Cell Phone Home Phone Work Phone Email Text All methods
How may this office convey your medical information to you? (Please circle all that apply)
Cell Phone Home Phone Work Phone Email Text All methods

Section IV – Office Policy

Financial- It is the policy of this office to collect all co payments due at the time of service. If a balance is due on your account, we will send you a statement for that balance. A total of only 2 statements will be sent. If no payment is received after the second notice, your account may be placed with an outside collection agency for settlement.

Appointments- This office is operated on an **appointment basis**. If you are more than 15 minutes late for your scheduled appointment, we as that you reschedule as a courtesy to others. For sit If you need to cancel an appointment, please call as soon as possible to let us know. Patients who continually do not show for their scheduled appointments without calling to cancel, will be asked to find care from another provider. You will be sent a certified letter informing you of this decision. There is a $50.00 charge for all no show, no call appointments per occurrence.

HIPPA - We will protect your right to privacy as outlined by HIPPA laws. Brochures are available throughout this office for your convenience. By signing below, you agree that you understand your rights under this policy.

Assignments- You agree to have all insurance payments sent directly to the doctor performing your service(s). We will file all charges as a courtesy for you to your carrier. There are times when medical information will be requested by your carrier in order to verify and process your charge(s). By signing below, you grant us the right to send this information on your behalf so that your charges may be settled.

Consent for Tx: I authorize medical treatment from Bethesda Medical Clinic, L.L.C. and its staff for conditions presented to by myself or those who have medical power of attorney over me.

_____________________________________ ______/_____/______
Patient Signature of Agreement **Date**