PATIENT INFORMATION
PLEASE PRINT

PATIENT

NAME - LAST, FIRST, M.I.			MAILING ADDRESS	
CITY		STATE	ZIP CODE	CELL PHONE #
TELEPHONE @ HOME	SEX	DATE OF BIRTH	AGE	MARITAL STATUS
SOCIAL SECURITY #			OCCUPATION	
EMPLOYER		EMPLOYER ADDRESS		
TELEPHONE @ WORK	LENGTH OF EMPLOYMENT		☐ FULL TIME ☐ PART TIME	
RACE	ETHNICITY		LANGUAGE	

RESPONSIBLE PARTY (person responsible for account balance due)

NAME -(IF OTHER THAN PATIENT) - LAST, FIRST, M.I.			RELATIONSHIP TO PATIENT
ADDRESS			TELEPHONE @ HOME
DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY #
OCCUPATION	EMPLOYER		
EMPLOYER ADDRESS			TELEPHONE @ WORK

SPOUSE OR PARENT (if other than responsible party)

NAME - LAST, FIRST, M.I.	ADDRESS	SOCIAL SECURITY #
EMPLOYER	ADDRESS	TELEPHONE @ WORK

IS THIS VISIT DUE TO AN ACCIDENT? ☐ Yes ☐ No If yes, please complete this section.

DATE OF ACCIDENT	TIME	LOCATION OF ACCIDENT	IS THIS WORKMAN'S COMP?
IF WORKMAN'S COMP, SUPERVISOR'S NAME		SUPERVISORS TELEPHONE #	VERIFIED BY
BRIEF EXPLANATION OF ACCIDENT			

MEDICAL COVERAGE INFORMATION (CARD COPY(S) ARE REQUIRED)

Please complete the information for the card subscriber (The person who the card is issued under)

INSURANCE COMPANY - PRIMARY		INSURANCE COMPANY - SECONDARY	
SUBSCRIBER'S NAME		SUBSCRIBER'S NAME	
ADDRESS		ADDRESS	
DATE OF BIRTH	SS#	DATE OF BIRTH	SS#
TELEPHONE #	EMPLOYER	TELEPHONE #	EMPLOYER
EMPLOYER'S ADDRESS		EMPLOYER'S ADDRESS	
EMPLOYER'S PHONE #	SUBSCRIBER'S RELATIONSHIP TO PATIENT	EMPLOYER'S PHONE #	SUBSCRIBER'S RELATIONS TO PATIENT

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Grand Lake Area Clinics to release any and all information requested by insurance companies or any public agency and its agents in determining benefits for services provided or benefits for related services. State law requires that we advise. "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to hepatitis, syphilis, gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS)."

PAYMENT POLICY/ASSIGNMENT OF BENEFITS

I hereby authorize payment of benefits be made directly to Grand Lake Area Clinics for services provided to me by Grand Lake Area Clinics. I understand I am financially responsible to Grand Lake Area Clinics for charges not covered by the assignment and I agree to abide by the financial policy as stated on the reverse of this form. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees.

CONSENT FOR HEALTH CARE

Patient voluntarily consents to such medical care including, but not limited to examination, diagnostic procedures or medical treatment which may be ordered by the physician, physician assistant, or nurse practitioner which they deem necessary or advisable.

SIGNATURE _____ DATE _____

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