PATIENT INFORMATION SHEET

PLEASE PRINT

DATE: _____

Last Name: _____ **Suffix:** _____ (Sr., Jr., etc.) **First Name:** _____ **Middle Name:** _____

Home Phone: (_____)_____ **Address:** _____

Cell Phone: (_____)_____ **City:** _____ **State:** _____ **Zipcode:** _____-_____

Work Phone: (_____)_____ **e-mail address:** _____

Birthdate _____/_____/_____ (month / day / year) **Employer:** _____

Sex: ☐ Male ☐ Female (check one) **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced (check one)

Social Security # _____-____-_____

Driver's License #: _____

Referred By: _____ **Primary Care Doctor & Phone:** _____ (_____) _____

(Please be specific: Doctor, Patient, Ad, Insurance Co., etc.)

Legal Guardian: _____ **Name & Phone # of Emergency Contact:** _____

May we leave a message at your Home _____ Office_____ Other _____

Name(s) of person(s) we can talk with in regard to information from our office. _____

Relationship _____

PRIMARY INSURANCE COVERAGE

Primary Insurance: _____

Responsible Party: ☐ Self ☐ Spouse ☐ Parent ☐ Other **Subscriber's Name:** _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Dependent ☐ Other _____

Subscriber's Address: _____ **City:** _____ **State:** _____ **Zipcode:** _____

Subscriber's Birthdate: _____/_____/_____ (month / day / year) **Social Security #:** _____

Subscriber's Phone Number: (_____) _____ **Work Phone:** (_____) _____ **Extension:** _____

Subscriber's Employer: _____ **Employer Address:** _____

(Name of Employer, Retired, None, or Full / Part-Time Student)

Effective Date of Insurance: _____ **Copayment: $** _____ **Policy #:** _____ **Group #:** _____

SECONDARY INSURANCE COVERAGE

Secondary Insurance: _____

Subscriber's Name: _____ **Subscriber's Address:** _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Dependent ☐ Other _____

Subscriber's Birthdate: _____/_____/_____ (month / day / year) **Social Security #:** _____

Subscriber's Phone Number: (_____) _____ **Subscriber's Employer:** _____

(Name of Employer, Retired, None, or Full / Part-Time Student)

Work Phone: (_____) _____ **Extension:** _____

Effective Date of Insurance: _____ **Copayment: $** _____ **Policy #:** _____ **Group #:** _____

FOR PEDIATRIC PATIENTS

Father's Name: _____ **Mother's Name:** _____

Address: _____ **Address:** _____

City, State, Zip: _____ **City, State, Zip:** _____

Home Phone #: (_____) _____-_____ **Home Phone #:** (_____) _____-_____

Work Phone #: (_____) _____-_____ **Ext:** _____ **Work Phone #:** (_____) _____-_____ **Ext:** _____

over →

PARTY RESPONSIBLE FOR CHARGES

For Workers Compensation, Accidents, etc.

☐ **(Check box if you are the responsible party)**

Bill To: _____

(Full Name - First, Middle, and Last)

Social Security #: _____-_____-_____ **Claim Type:** ☐ Self ☐ Wrk Comp ☐ PIP ☐ MVA

Name: _____ **Address:** _____

(Apt# or P.O. Box): _____ **City:** _____ **State:** _____ **Zip:** _____

Case Type: _____ **File #:** _____ **Adjuster:** _____

Accident or Illness Onset Date: _____/_____/_____ **Accident State:** _____ **First Dr. Visit Date:** _____/_____/_____

Accident Description: _____

Accident Address: _____

CONSENT & ASSIGNMENT

PLEASE READ BEFORE SIGNING

***** Medicare *****

I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (Title XVIII). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

***** Blue Shield of Maryland *****

I understand the charge of a non-participating physician may exceed the Blue Shield of Maryland, Inc. payment and, if greater, I will be responsible for that amount. I authorize release of any medical information necessary to process this claim. For charges of a participating provider, I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

***** Legal Assignment ***** (applicable to Physician Services)

The undersigned expressly agrees that if, upon default, this matter is referred for collection, the undersigned agrees to pay an attorney's fee of fifteen percent (15%) of the outstanding balance at the time of referral, which percentage and the amount resulting therefrom are considered reasonable by the undersigned, and any and all court costs incurred therewith, as well as private process server fees.

***** Insurance Assignment *****

I authorize and assign payment directly to the physician involved in my treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges **not covered** by my insurance.

***** Managed Care *****

I understand that, without an authorization/referral form from my HMO/PIPA/PPO, I will be financially responsible for charges I incur.

***** GUARANTEE *****

As an inducement for the providing of services to the patient, the undersigned absolutely and unconditionally guarantees to Dr. Wilhelmsen & Associates, P.A. and its successors and assigns, the full and complete payment due by the patient, as and when the same becomes due.

Signature: _____ **Date:** _____/_____/_____

(sign here)

***** Signature of Patient, Responsible Party, Parent, or Legal Guardian *****

Sign Here: _____ **Date:** _____/_____/_____

I authorize a copy of this authorization to be used in place of the original.