Shands Medical Group at Magnolia Parke

PATIENT INFORMATION

Today's Date _____

PATIENT INFORMATION

1. PATIENT NAME _____ (LAST) _____ (FIRST) _____ (MIDDLE)
2. ADDRESS 1 _____
   ADDRESS 2 (LOT #, APT #) _____
   CITY _____
3. ☐ MALE ☐ FEMALE ☐ EMPLOYED ☐ STUDENT ☐ RETIRED
4. EMPLOYER/SCHOOL _____
5. IF STUDENT, PERMANENT/PARENT'S ADDRESS _____ PHONE # _____
6. HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____
7. DATE OF BIRTH _____ SS # _____ DRIVER LIC. _____ STATE _____
8. ☐ SINGLE ☐ MARRIED ☐ OTHER _____
   IF MINOR CHILD – PARENTS NAMES: FATHER _____ MOTHER _____
   FATHER'S WORK PHONE # _____ MOTHER'S WORK PHONE # _____
9. REFERRED BY _____
10. PERSON WHO DOES NOT LIVE WITH YOU TO CONTACT IN CASE OF AN EMERGENCY: _____
    NAME: _____ PHONE: _____ RELATIONSHIP: _____

PRIMARY INSURANCE INFORMATION

11. SUBSCRIBER'S NAME _____ DOB ____/____/____ (mm/dd/yy) AGE _____
12. SEX _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____
13. PHONE # ( ) _____ SOC. SEC. # _____
14. EMPLOYER'S NAME _____
15. ADDRESS _____ CITY _____ STATE _____ ZIP _____
16. INSURANCE PLAN/PROGRAM NAME _____
17. INSURANCE ID # _____ POLICY OR GROUP # _____

SECONDARY INSURANCE INFORMATION

☐ NONE

18. SUBSCRIBER'S NAME _____ DOB ____/____/____ (mm/dd/yy) AGE _____
19. SEX _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____
20. PHONE # ( ) _____ SOC. SEC. # _____
21. EMPLOYER'S NAME _____
22. ADDRESS _____ CITY _____ STATE _____ ZIP _____
23. INSURANCE PLAN/PROGRAM NAME _____
24. INSURANCE ID # _____ POLICY OR GROUP # _____

Please Fill Out Reverse Side

LIFETIME AUTHORIZATION *(page 2 of 2)*

INSURANCE ASSIGNMENTS AND AUTHORIZATIONS TO RELEASE INFORMATION FORM

I. RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental agency, example: Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II. PHYSICIAN INSURANCE TREATMENT - I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family services or its intermediaries or carriers any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

DATE _____ PATIENT _____
Signature

SUBSCRIBER (if different from patient) _____
Signature

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE

MEDIGAP (SECONDARY INSURANCE) SIGNATURE

_____ _____
NAME OF BENEFICIARY HEALTH INSURANCE COMPANY

_____
MEDIGAP POLICY NUMBER

I request that payment of authorized MEDIGAP benefits be made on my behalf to _____ for any services furnished me by (physician/supplier). I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services.
(Insurance Company)