PRIMARY CARE SPECIALISTS, LLC.
PATIENT INFORMATION SHEET

Please PRINT ALL Information

PATIENT INFORMATION

Who is responsible for patient ☐ Self ☐ Parent Other________ Social Security # ___-___-___ Sex ☐ M ☐ F

Name ____
Last First Middle

Address ____
Street City State Zip

Telephone # (   )________ Cell/Beeper/Other # (   )________ E-mail Address________

Date of Birth___/___/___ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Other________

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Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired Other________ Student ☐ Full-Time ☐ Part-Time

Employer Name ________________ Occupation________________

Employer Address________________ Employer Phone (   )________

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Spouse / Parent Name ________________ SSN # ___-___-___ DOB___/___/___
Last First Middle

Emergency Contact Name________ Phone Number (   )________ Their Relationship to You________

INSURANCE INFORMATION

INSURED PERSON (If not patient)

Name ________________ Social Security # ___-___-___
Last First Middle

Date of Birth___/___/___ Relationship to patient________________

PRIMARY INSURANCE

Insurance Carrier ________________________________
Name Address Phone Number

Policy No.________________ Group No.________________

SECONDARY INSURANCE

Insurance Carrier ________________________________
Name Address Phone Number

Policy No.________________ Group No.________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS I authorize the release of all medical information necessary to process this claim that is pertinent to my medical care. I assign all medical and/or surgical benefits to my physician. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Signature (patient if minor)________________ Date________

MEDICARE AUTHORIZATION TO RELEASE INFORMATION AND MEDICARE ASSIGNMENT I request payment of authorized Medicare benefits to be made on my behalf to my physician for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR NON-COVERED SERVICES AS EXPLAINED TO ME BY THE PHYSICIAN. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Signature (patient)________________ Date________