Heritage Valley Health System

____ Tri State Medical Group ____ Tri State Pediatric Group ____ Tri State OB/GYN ____ Sewickley Valley Medical Group

PATIENT INFORMATION

NAME: LAST | FIRST | MIDDLE INITIAL | SEX M F | BIRTHDATE

ADDRESS: STREET | CITY | STATE | ZIP | TELEPHONE # ( ) | MARITAL STATUS S M W Sep Div

SOCIAL SECURITY # | E-MAIL ADDRESS | **RACE** (CIRCLE ONE) American/AK Indian; Black/African American Asian/Pacific Islander; Hispanic; White Unknown/ Decline | **ETHNICITY** (CIRCLE ONE) Not of Hispanic Origin Hispanic Origin Unknown/ Decline | OCCUPATION (CIRCLE ONE) FT PT RET Not Employed

CELL# | ALTERNATE# |

EMPLOYER OR NAME OF SCHOOL | ADDRESS | TELEPHONE # ( ) | ARE YOU A STUDENT? Yes No Part time Full time

SPOUSE, PARENT OR GUARDIAN INFORMATION *(If under 18, name of parent with whom you reside)*

NAME: LAST | FIRST | MIDDLE INITIAL | SEX M F | BIRTHDATE

ADDRESS: STREET | CITY | STATE | ZIP | TELEPHONE # ( ) | RELATIONSHIP TO PATIENT Spouse Parent Other

SOCIAL SECURITY # | EMPLOYER NAME AND ADDRESS | EMPLOYER TELEPHONE # ( )

INSURANCE INFORMATION ****PLEASE HAVE CARDS READY FOR STAFF TO COPY****

NAME OF **PRIMARY INSURANCE CO.**

INSURED'S NAME (**Subscriber of insurance**) SUBSCRIBER'S BIRTHDATE

HOLDER'S RELATIONSHIP TO PATIENT: Circle one
Self Spouse Natural Child with financial responsibility Step Child
Natural Child without financial responsibility Adopted Child Foster Child
Significant Other Life Partner Grandchild Organ donor
Other :Specify:_____

ID # OR AGREEMENT # GROUP # EFFECTIVE DATE

AMOUNT OF CO-PAY FOR OFFICE VISITS and SPECIALIST'S VISITS:

NAME OF **SECONDARY INSURANCE CO**

INSURED'S NAME (**Subscriber of insurance**) SUBSRIBER'S BIRTHDATE

HOLDER'S RELATIONSHIP TO PATIENT: Circle one
Self Spouse Natural Child with financial responsibility Step Child
Natural Child without financial responsibility Adopted Child Foster Child
Significant Other Life Partner Grandchild Organ donor
Other Specify:_____

ID # OR AGREEMENT # GROUP # EFFECTIVE DATE

DO YOU HAVE OTHER INSURANCE THAT WILL PAY THIS ACCOUNT?
You are required to complete an additional form.

o Automobile o Other_____
o Workmen's Comp o None

Will patient be best served in a language other than spoken English? : ° No ° Yes If yes, please specify_____

EMERGENCY CONTACT

PLEASE NAME A PERSON *WHO DOES NOT LIVE WITH YOU* TO CONTACT IN CASE OF AN EMERGENCY OR IN THE EVENT WE ARE UNABLE TO REACH YOU.

NAME / RELATIONSHIP: TELEPHONE # - HOME ( ) TELEPHONE # - WORK ( )

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to either: **Tri State Medical Group/ Tri State Pediatric Group/ Tri State OB/GYN/ Sewickley Valley Medical Group/ as noted above.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED: _____ DATE: _____
PATIENT OR RESPONSIBLE PARTY

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