Heritage Valley Medical Group, Inc.

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 # | DRIVER'S LICENSE # | OCCUPATION | CIRCLE ONE FT PT RET Not Employed

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

o Automobile o Other _____

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

o Workmen's Comp o None

EMERGENCY CONTACT

PLEASE NAME A PERSON *WHO DOES NOT LIVE WITH YOU* TO CONTACT IN CASE OF AN EMERGENCY OR IN THE EVENT THAT 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: **Heritage Valley Medical Group, Inc./ 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

Rev 1/2003