| PATIENT INFORMATION | Last Name | First Name | Middle Initial |
|---|---|---|---|
| Permanent Address | City | State | Zip |
| Home Telephone | Race | Religion | E-mail Address |
| Daytime Phone | Marital Status | DOB | Social Security # | Gender |
| Mother's Name (If patient is a minor) | Father's Name (If patient is a minor) | | |

| GUARANTOR | Last Name | First Name | Middle Initial |
|---|---|---|---|
| Permanent Address | City | State | Zip |
| Home Telephone | Relationship to Patient | DOB | Social Security # | Gender |
| Employer | | | |
| Employer's Address | City | State | Zip |
| Employer's Telephone Ext. | Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown | | |

| PATIENT EMPLOYMENT | Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown | | |
|---|---|---|---|
| Occupation | Employer | | |
| Address | City | State | Zip |
| Employer's Telephone Ext. | Employer's Telephone Ext. | | |

| PRIMARY INSURANCE | Primary Insurance Company |
|---|---|
| Relationship to Subscriber | Policy Effective Date |
| Insured Name | Subscriber ID or Medicare No. |
| Group No. | Plan No. |
| Subscriber's Employer | |

| SECONDARY INSURANCE | Secondary Insurance Company |
|---|---|
| Relationship to Subscriber | Policy Effective Date |
| Insured Name | Subscriber ID or Medicare No. |
| Group No. | Plan No. |
| Subscriber's Employer | |

⇨ SEE BACK SIDE

| NEXT OF KIN INFORMATION | Last Name | First Name | Middle Initial |
|---|---|---|---|
| Permanent Address | City | State | Zip |
| Home Telephone: | Daytime Telephone: | Relationship: | |

| PERSON TO NOTIFY | Last Name | First Name | Middle Initial |
|---|---|---|---|
| Address | City | State | Zip |
| Home Telephone: | Daytime Telephone: | Relationship: | |

## MEDICAL CONSENT

I consent to all medical and surgical treatment, laboratory, diagnostic imaging and other medical procedures performed and prescribed by the health care provider during clinic visits.

*Signature* *Date/Time*

## FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for any unpaid balance. I hereby authorize my insurance benefits to be paid directly to my provider. I authorize my provider or insurance company to release information required for processing my claims.

*Signature* *Date/Time*

## AUTHORIZATION FOR TREATMENT OF A MINOR

I authorize treatment of the above patient who is a minor and hereby state that I am the natural parent or legal guardian having custody of the named minor.

*Signature* *Date/Time*

## MEDICARE PATIENTS ONLY

## STATEMENT TO PERMIT PAYMENT OF MEDICARE TO PROVIDER & PATIENTS

Name of beneficiary: ______________________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf for services furnished to me at Island Hospital Family Care Clinics. I authorize any holder of medical or other information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits for related services.

*Signature* *Date/Time*