THANK YOU FOR BEING A PART OF MASONBORO FAMILY MEDICINE, P.C.
WE'RE GLAD YOU ARE HERE!

PATIENT INFORMATION SHEET *PLEASE COMPLETE ALL SECTIONS*

Name____
(PATIENT'S FIRST NAME) (MIDDLE INITIAL) (LAST NAME) (NICKNAME)

☐ M ☐ F ___________/______________/________________ _____________/____________/_______________
(DATE OF BIRTH) (SOCIAL SECURITY NUMBER)
MARRIED_______ SINGLE________ WIDOWED_________ DIVORCED________

Primary Language___________ Race: American Indian____ African American___ Asian____ Caucasian____ Hispanic____ Other____
Refused____

Name____
(RESPONSIBLE PARTY'S FIRST NAME) (LAST NAME) (MIDDLE INITIAL)

Address____
(STREET ADDRESS) (PO BOX) (CITY/STATE/ZIP CODE)

Telephone_____________________________________/_____________________________________/_____________________________
(PRIMARY CONTACT) (WORK) (ALTERNATE CONTACT)

Employer____
(EMPLOYER NAME) (OCCUPATION)

☐ Full Time ☐ Part Time ☐ Retired ☐ Student

In case of emergency call: ____
(NAME) (DAY TIME TELEPHONE)

____
(NAME) (DAY TIME TELEPHONE)

****Primary Insurance Information**____
(NAME OF INSURANCE COMPANY)

________________________________ _________/_______/______ ☐SPOUSE ☐CHILD ☐ ______________________________
(SUBSCRIBER/POLICY HOLDER) (DATE OF BIRTH) (RELATIONSHIP TO PATIENT)

****Secondary Insurance Information**____
(NAME OF INSURANCE COMPANY)

____________________________ _________/____________/_________ ☐SPOUSE ☐CHILD ☐ ______________________________
(SUBSCRIBER/POLICY HOLDER) (DATE OF BIRTH) (RELATIONSHIP TO PATIENT)

ASSIGNMENT AND RELEASE OF INFORMATION

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliance resolutions. I authorize payment directly to MASONBORO FAMILY MEDICINE, P.C. for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. I understand that while MASONBORO FAMILY MEDICINE, P.C. will make every effort to notify me that a service may not be covered by my insurance, I agree that I will be financially responsible for any services considered not covered by my insurance. A photocopy of this authorization shall be considered as effective and as valid as the original.

May we leave normal lab results on your answering machine/ voice mail/ cell phone? YES / NO
Besides yourself, who may we discuss your medical information (including lab & x-ray results) billing information?

____ ____
(NAME) (TELEPHONE) (NAME) (TELEPHONE)

____ ____
(PATIENT OR RESPONSIBLE PARTY SIGNATURE) (RELATIONSHIP TO PATIENT)

___________/________________/______________
(DATE)

(**WE REQUIRE A COPY OF YOUR INSURANCE CARD TO FILE YOUR INSURANCE)