FRANCE AVENUE FAMILY PHYSICIANS

Patient Name* ________________________________ Patient Birthdate*______________ Race ______

Patient Social Security Number* ___________Patient Sex ___Age ____ Language Preference _______

Billing Address* _______________________ Home Phone* ____________________________

, _______________________ Email Address ___________________________

Marital Status _________ Responsible Party (self-unless under age 18)* _____________________________

Patient Employer ______________________________ Work Phone ____________________

Spouse/Parent Name ___________________________ Spouse/Parent Employer ______________________

Emergency Contact * ___________________ Phone ____________

Patient Preferred method of communication ❑ Home Phone ❑ Work Phone ❑ Other ___________

INSURANCE INFORMATION----*ALL INFORMATION MUST BE COMPLETED FOR FRANCE AVENUE FAMILY PHYSICIANS TO SUBMIT YOUR INSURANCE CLAIMS.

1st Insurance* _________________ ID Number* ________________

Subscriber (insured) Name* ______________ Subscriber ID* ________________

Subscriber SSN* ____________ Subscriber Sex*____ Subscriber Birthdate* _____________

2nd Insurance* _________________ ID Number* _______________

Subscriber (Insured) Name*___ _____ Subscriber ID* ____________________

Subscriber SSN* __________________ Subscriber Sex* ____ Subscriber Birthdate* ______________

Prescription Drug Insurance (if different from Health Insurance) ____

Release of Records and Benefits Assignment Authorization

I hereby authorize France Avenue Family Physicians to furnish information concerning my illness and treatments to Insurance Carriers and Physicians directly involved in my care. I authorize payment of any medical benefits to France Avenue Family Physicians. I certify that the above information is correct and that I am responsible for payment of services rendered. I permit a copy of this authorization to be used in place of the original.

Patient Signature ____ 4/8/2010

Medicare Authorization

I request that payment of authorized medical benefits be made on my behalf to France Avenue Family Physicians for services furnished me by this clinic. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits payable or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Patient Signature ____4/8/2010

If this visit is the result of a Work Comp Injury or Auto Accident, please notify the front desk staff.