CONFIDENTIAL DATA

INDIANA INTERNAL MEDICINE CONSULTANTS – INDIANA PRIMARY CARE ASSOCIATES
CENTER FOR RESPIRATORY & SLEEP MEDICINE – INDIANA INFECTIOUS DISEASE CONSULTANTS

Date ___________ Patient's Date of Birth ______________ Patient's Social Security Number ________________

Legal Name ____
Last First MI Preferred name

Home address ____
Street City State Zip code

Home Phone # ____________________ Cell Phone # ___________________ Other Phone # _______________

E-mail address ____ May we contact you by e-mail: □ Yes □ No

Patient Sex □ Male □ Female **Relationship Status:** □ Married □ Single □ Widowed □ Divorced □ Other

Referring Physician ______________________________
(First) (Last)

Address ____

Phone # ____

Family Physician _________________________________
(First) (Last)

Address ____

Phone # ____

Name of Employer ____ Employer Phone _______________________

Name of Spouse ____________________________ Spouse Work# ________________ Spouse Cell# ________________

Name & phone number of nearest relative not living with you: Name ____________________ Phone# _______________

IN ORDER FOR US TO FILE WITH YOUR INSURANCE COMPANY, ALL INFORMATION IN THIS SECTION MUST BE COMPLETE & ACCURATE. YOU MUST FILL THIS OUT EVEN THOUGH YOUR INSURANCE CARD HAS BEEN COPIED

Primary Insurance ______________________________

Policy Holder ___________________________________
□ Male □ Female

Relationship ____________________________________

DOB ____

Employer _______________________________________

Secondary Insurance ____________________________

Policy Holder ___________________________________
□ Male □ Female

Relationship ____________________________________

DOB ____

Employer _______________________________________

Please note: This information is requested for your protection, incorrect information supplied could result in your insurance not paying for services, leaving you responsible for the balance. If you are unsure of any information, we can make a telephone available for you to retrieve information. If you have any questions, please feel free to ask the receptionist.

RELEASE OF INFORMATION

I hereby authorize insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services or items processed as patient responsibility per the insurance. I also authorize the physician to release information required to process claims and agree that a photocopy of this authorization is as valid as the original. If for any reason you request your medical records to be sent to anyone, i.e. yourself, physician, attorney, etc, you **will** be charged a fee, unless **we** refer you to another physician.

Signature ____ **Date** ___________________________________