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

Race**:** □ A= Asian □ B= African American Black □ I= Hawaiian or Pacific Islander □ N= American Indian or Ak Nat
□ W= White Caucasian □ O= Other □ P= Declined

Language**:** □ L= American Sign Language □ A= Arabic □ B= Burmese □ C= Hakha Chin □ E= English □ H= Hindi
□ P= Panjabi □ S=Spanish □ D= Declined □ O=Other

Ethnic: □ H= Hispanic or Latino □ N=Not Hispanic or Latino

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 <u>MUST</u> 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 **<u>will</u>** be charged a fee, unless **<u>we</u>** refer you to another physician.

Signature _____ **Date** _____