

# INTERNAL MEDICINE GROUP PATIENT INFORMATION

TODAY'S DATE \_\_\_\_\_

Patient Name \_\_\_\_\_  
First Middle Last

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex M F

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Marital Status Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

## COMPLETE THIS SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT IS FINANCIALLY RESPONSIBLE.

Responsible Party \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone (\_\_\_\_\_) \_\_\_\_\_ Work Telephone (\_\_\_\_\_) \_\_\_\_\_ SS # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION

### PRIMARY

Name and Address of Company \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Insured's Name \_\_\_\_\_

Group # \_\_\_\_\_ Policy ID# \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_

### SECONDARY

Name and Address of Company \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Insured's Name \_\_\_\_\_

Group # \_\_\_\_\_ Policy ID# \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_

Other Insurance \_\_\_\_\_

## IN CASE OF EMERGENCY, CONTACT: \_\_\_\_\_

Relationship \_\_\_\_\_ Home Telephone (\_\_\_\_\_) \_\_\_\_\_ Work Telephone (\_\_\_\_\_) \_\_\_\_\_

How did you learn about Internal Medicine Group? \_\_\_\_\_

Referred by \_\_\_\_\_

*I hereby authorize medical treatment of the above named person and agree to be financially responsible for all charges for such treatment, including costs of collection and legal fees (if applicable). I hereby assign payments to Internal Medicine Group. I authorize Internal Medicine Group to release any medical information necessary to process my insurance claims. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a late date.*

Signature \_\_\_\_\_ Date \_\_\_\_\_