Pontiac Trail Medical Center

Information Form

PATIENT INFORMATION Date _____

Name _____ Birth date_____ Sex: M F

Address _____ City _____State_____ Zip_____

Phone ( ) _____ Bus. Phone ( ) _____ Soc Security #_____

Employer _____ Employer Phone _____

FINANCIALLY RESPONSIBLE PARTY (if other then patient)

Name _____Relationship _____ Birth date_____

Address _____City _____ State_____ Zip _____

Phone ( ) _____ Bus. Phone ( ) _____Soc Security #_____

EMERGENCY CONTACT INFORMATION

Contact Name _____ Phone ( ) _____

INSURANCE INFORMATION

Primary Carrier _____

Subscriber name_____ Birth date _____ Soc Security #_____

Secondary Carrier _____

Subscriber name _____ Birth date _____ Soc Security # _____

Employer _____ Employer phone _____

Please give the receptionist your insurance card(s)

FINANCIAL RESPONSIBILITY

In an effort to contain health care costs, we will make every effort to verify your health care benefits. Unfortunately, if we are unable to verify your coverage or your health plan has a primary care physician that is not one of the physicians in the office, you will be responsible for any costs incurred and not paid for by your insurance company.

I authorize the release of medical records necessary for insurance purposes and authorize payment of applicable benefits to the physician that provides service. I agree to pay all charges not covered by my insurance plan or workman's compensation carrier.

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default.

By signing below I acknowledge that I have been given a copy of PONTIAC TRAIL MEDICAL CENTER'S financial policy and am in agreement with the terms.

_____ Date _____

Signed (Patient, parent, legal guardian)

Rev. 11/18/04