Family Health Center at Quakerbridge
Patient Information Sheet

Patient Information

Patient Name:_____ Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cellular Phone:_____

Sex: M F Marital Status: S M W D P Social Security No: _____

Employer: _____ Work Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian: (person to be billed if patient is under age 18)

Name: _____ Home Phone:_____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____ Work Phone: _____

Work Address: _____

City:_____ State: _____ Zip: _____

Primary Insurance Company: _____ Group #: _____

Policy/ID#: _____ Patient Relationship to Subscriber: _____

Subscribers Name: _____ Date of Birth: _____ Social Security Number: _____

Secondary Insurance Company:_____ Group #: _____

Policy/ID#: _____ Patient Relationship to Subscriber: _____

Subscribers Name: _____ Date of Birth: _____ Social Security Number: _____

Other Insurance: _____

Have you filed a claim for Worker's Compensation? YES NO Date of injury _____

Name of employer/insurance company _____ Telephone #_____

Have you filed a claim for an Auto Accident? YES NO Date of accident _____

Name of auto insurance company _____ Telephone # _____

Patient Signature _____ Date:_____

Email Address: _____ To be used for future reminders……Thank you.

In Case of Emergency, Contact: _____ Relationship: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cellphone: ( ) _____

Please read, sign and date the following to allow us to bill your insurance company for your medial care:

I have completed this form and certify that I am the Patient or duly authorized agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment for services. I authorize the release of medical history, information, or records concerning my diagnosis and treatment by the Family Health Center required to substantiate or explain insurance claims filed, and I authorize payment directly to Family Health Center and permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing.

If I have Medicare coverage, I request that payment of authorized Medicare benefits be made either to me or on my behalf to Family Health Center for any services furnished to my by that physician or supplier. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). I authorize any holder of medical information about me to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

_____ _____

Signature of Patient or Authorized Person (Address/Relationship) Date

If I have Medigap coverage, I request that payment of authorized Medigap benefits be made either to me or on my behalf to Family Health Center for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release to: _____any information needed to determine these benefits payable for related services.

Name of Medigap Insurer

_____ _____

Signature of Patient or Authorized Person (Address/Relationship) Date

I have read and understood the attached, and there are no changes to the information provided.
(To be resigned once a year)

Signature: _____ Date:_____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____