BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

PATIENT INFORMATION

Name _____
Last First Middle Any Other Preferred First Name

Address _____
Street or P.O. Box Apt. #

_____
City State Zip

Home Phone _____ Work Phone _____ Ext. _____

Cellular Number _____ Email Address _____ ◯ Work / Home ◯

Sex ◯ Male / Female ◯ Birth Date _____ Marital Status _____ Referred By: _____

Ethnicity: **Please select one:** Non Hispanic • Hispanic • Decline to Answer
Race: **Select one:** White • Black • Asian • Native American/Eskimo • Pacific Islander • Other/Unknown• Decline to Answer

Social Security # _____ Driver's License # _____

Employer _____ Spouse or Parent Name & Work Phone _____

Pharmacy Name / Location _____ Pharmacy Phone _____

PRIMARY INSURANCE HOLDER (or Person Responsible for the Bill):

☐ PLEASE CHECK IF RESPONSIBLE PARTY IS A PATIENT OF THIS PRACTICE
(Fill out any information that is different from above)

Name _____
Last First Middle **Relation to Patient**

Address _____
Street or P.O. Box Apt. #

_____
City State Zip

Sex ◯ Male / Female ◯ Birth Date _____ Social Security # _____

Home Phone _____ Pager or Cellular Number _____

Employer _____ Work Phone _____ Ext. _____

Primary Insurance Co. _____

Secondary Insurance Co. _____

EMERGENCY INFORMATION ☐ Please check if primary contact is a patient of this practice.

Contact in case of emergency – List at least two people and include phone numbers and relation: _____

_____

In order to keep costs at a minimum for our patients, we do not bill. We would appreciate payment at the time services are rendered. If you have insurance with one of the groups with which we participate, we will file a claim. We will provide to all others a statement with the information required by your insurance company so that you can easily forward your claim to them. Any bills that you are responsible for and are not paid within 60 days will be assessed a "BILLING PROCESSING fee" of $20 and be charged 18% per annum interest.

Insurance Authorization and assignment

I hereby authorize BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE to release my insurance carrier any information concerning my illness and treatment, including possible HIV, AIDS, psychiatric or drug & alcohol information. I hereby assign to the physician all payments for medical services rendered to myself and dependents. I understand that I am responsible for any amount not covered by my insurance.

Medical Consent

I authorize all medical providers at BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE to treat me medically in the office or hospital for any illness or injury that I may incur.

Signature of Patient or Responsible Party _____ Date _____

12/2015

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