Southern Indiana Physicians

Patient Name______________________________________ / ______________
First Name   Middle Initial   Last Name   Previous Last Name

S.S. #______________ **Birthdate**______________ ☐Female ☐ Male

Address______________________ **City**______________ **State**________ **Zip**__________

Home Phone______________ **Work Phone**______________ **Cell Phone**______________

Employer______________________ **Email**______________________

Family Doctor______________________ **Referring Doctor**______________________

Spouse Name______________________ **Social Security #**______________

Date of Birth______________ **Phone number #**______________

Marital Status ☐ Single ☐ Married ☐Divorced ☐Widowed ☐ Separated / Previous Last Name__________

Employment ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Self Employed ☐ Military

Student ☐ Full Time ☐ Part Time ☐ Not a Student

Race ☐Black/African American ☐ White ☐ Asian ☐ Native Hawaiian
☐American Indian/Alaska Native ☐ Mixed Race ☐Other Pacific Islander ☐ Other

Ethnicity ☐Hispanic/Latino ☐ Not Hispanic/Latino

Primary Language Spoken ☐ English ☐ Spanish ☐ French ☐ Creole ☐ Other______________

Responsible Party Information (if other than the patient):

Name______________________________________ **Relationship**______________
First Name   Middle Initial   Last Name

Social Security #______________ **Date of Birth**______________ **Phone #**______________

Address______________________ **City**______________ **State**________ **Zip**______

Emergency Contact______________________ **Phone #**______________ **Relationship**__________

Insurance Info:

Primary Insurance______________________________ **Employer**______________

Subscribers Name______________________ **Date of Birth**______________ **Relationship**__________

Address if different than Patient's or Guarantor's______________________________

Secondary Insurance______________________________ **Employer**______________

Subscribers Name______________________ **Date of Birth**______________ **Relationship**__________

Address if different than Patient's or Guarantor's______________________________

Can we leave a message on your voicemail and/or answering machine: ☐ Yes ☐ No

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Medicare Patients Only: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my provider who treats me to release information from my medical record to the Social Security Administration and /or the Medicare program or its intermediaries or carriers, or to the Professional Standards Review Organizations for processing of claims for medical benefits. I authorize payment of benefits to be made directly to my provider treating me on my behalf.

Initial________________

Consent to Treat: I request and give consent to my provider and perform such medical/surgical care, test, procedure, drugs and services and supplies as are considered necessary or beneficial for my health and wellbeing. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon me.

Initial________________

Release of Medical Information and Authorization to Pay Insurance Benefits: I authorize my provider to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits to my provider on my behalf.

Initial________________

Financial Agreement: I understand all accounts are the full responsibility of the patient and / or the responsible guarantor. My provider will assist patients in obtaining insurance benefits when those benefits are assigned to my provider. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my provider. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection cost and reasonable attorney fees incurred to collect any outstanding balances on my account.

Initial________________

HIPAA Information: I acknowledge that I have been offered a copy of this office's HIPAA Notice of Privacy Practices. This notice describes how medical information about me may be used and / or disclosed and how I can access this information. The Notice of Privacy Practices is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance.

Initial________________

Responsible Party Signature____Date__________________

Patient Name____