IU Health Physicians

A

PATIENT INFORMATION (ADULT)

COMPLETING AND SIGNING THIS FORM IS A CONDITION OF BEING A PATIENT AT IU HEALTH PHYSICIANS

Please be sure every space is filled out. If it does not pertain to you, please put N/A. **MRN #:** _____

PATIENT'S LEGAL NAME: *(Last, First, Middle Initial, Nickname)*

Home Address *(Street, Apt. #).* Social Security #

City, State Zip Home Phone #

Patient's Email Address Cell #

Date of Birth | Sex ☐ Male ☐ Female | If 18-25, your Student Status ☐ Full-Time ☐ Part-Time ☐ N/A

Marital Status
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

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

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined ☐ Unknown

Preferred Language of Communication
☐ English ☐ Spanish ☐ Other _____

Patient's Employer Name

Patient's Employer Address Work Phone #

In Case of Patient Emergency, Please Contact – Name: Relationship

Emergency Contact Phone Numbers
Home _____ Cell _____ Work _____

GUARANTOR NAME: *(Person Signing Form)* Social Security #

Home Address *(Street, Apt. #)*

City, State Zip Home Phone #

Date of Birth | Sex ☐ Male ☐ Female | Cell Phone #

Guarantor's Email Address Work #

Guarantor's Employer Name

Guarantor's Employer Address Employer Phone

Preferred Method of Communication
☐ Email ☐ Mail ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Declined

OTHER PHONE NUMBERS
Home: Work: Cell:

INSURANCE INFORMATION *This Section MUST Be Completed.*

Please give the receptionist your insurance card(s) to photocopy. (Insurance claims will not be filed without a copy on file.)

Is the patient covered under more than one plan? ☐ Yes ☐ No

PRIMARY INSURANCE: Insurance Company Name: _____ Member ID #: _____

Primary Insurance Address: _____

Group #: _____ Insurance Effective Date: _____ CoPay: ☐ Yes ☐ No Amount: _____

Policyholder's Name: _____ Relationship to Patient: _____

SS#: _____ / _____ /_____ Policyholder's DOB: _____ Address: _____

Employer Name: _____

SECONDARY INSURANCE: Insurance Company Name: _____ Member ID #: _____

Secondary Insurance Address: _____

Group #: _____ Insurance Effective Date: _____ CoPay: ☐ Yes ☐ No Amount: _____

Policyholder's Name: _____ Relationship to Patient: _____

SS#: _____ / _____ /_____ Policyholder's DOB: _____ Address: _____

Employer Name: _____

FOR ALL PATIENTS **This *MUST* be signed and dated by the patient, unless a minor, or if patient has a legal guardian; then parent or legal guardian must sign and date. Your signature indicates that the information is current and accurate.**

UPDATED PATIENT INFORMATION AND ASSIGNMENT:

_____ _____
Signature Date

UPDATED PATIENT INFORMATION AND ASSIGNMENT:

_____ _____
Signature Date

UPDATED PATIENT INFORMATION AND ASSIGNMENT:

_____ _____
Signature Date

I recognize and accept responsibility for payment of services rendered regardless of insurance coverage. This includes, but is not limited to, coinsurance, co-payment, deductive and non-covered services. I authorize payment directly to my physician for any benefits due for the services rendered. I understand that, should it become necessary to file suit to recover any uncollected charges, I will be responsible for all court costs, reasonable attorney fees, and interest due. Please be advised that your physician may furnish information to other physicians, insurance carriers and other related entities concerning the illness or medical treatment of this patient for legitimate business purposes as authorized by IC 16-35-5 et seq.

_____ _____
Signature of Patient or Responsible Party (Guarantor) Date