

Patients First Medical Clinic

Patient Billing Information

Patients Last Name: _____ First Name: _____ Middle Initial: _____

Parent's Name (if patient is a child): _____ Parent's Social Security #: _____

Sex: _____ Marital Status: _____ Date of Birth: _____ Patients Social Security #: _____

Mailing Address: _____ City: _____ State: _____

Zip Code: _____ Home phone #: _____ Cell phone #: _____

Physical Address:(if different from above) _____

City: _____ State: _____ Zip Code: _____ E-mail Address: _____

Medicaid/Denali Kid Care ID#: _____ Responsible Billing Party: _____
(if responsible party has different address, please list in mailing address)

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you learn about our clinic? _____

Employer: _____

Address: _____

City, State, Zip Code: _____

Phone #: _____

Occupation: _____

Employee Type:

Retired

Employed Full Time

Employed Part Time

Not Employed

Student Type:

Student Full Time

Student Part Time

Non-Student

Insurance #1: _____

Address: _____

City, State, Zip Code: _____

Phone #: _____

Policy (ID) Number: _____

Group Number: _____

Insured Name: _____ Sex: _____

Marital Status: _____ SSN#: _____

Relationship to patient: _____

Date of Birth (insured): _____

Employer: _____

City, State, Zip Code: _____

Insurance #2: _____

Address: _____

City, State, Zip Code: _____

Phone #: _____

Policy (ID) Number: _____

Group Number: _____

Insured Name: _____ Sex: _____

Marital Status: _____ SSN#: _____

Relationship to patient: _____

Date of Birth (insured): _____

Employer: _____

City, State, Zip Code: _____

Consent to Treatment

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor by signing I give consent for examination, tests, and/or procedures for the above named minor patient.

X _____

I authorize the release of any information necessary to process my insurance claims and assign and request payment directly to the provider(s). I understand that I may revoke this consent at anytime in writing to this office. I further understand that I am responsible for payment for all products and services rendered to me or any patient for which I am the guarantor of payment. All unpaid balances forwarded to collections will have an additional fee added and are the patient's responsibility. I have read and understand the above statement.

Date: _____

X _____

FOR OFFICE STAFF USE ONLY

Primary: Deductible: _____ Co-Pay: _____ OOP Max: _____ ED: _____

Secondary: Deductible: _____ Co-Pay: _____ OOP Max: _____ ED: _____