Manhan Internal Medicine

Patients Name: _____ Date of Birth _____

Sex M F Social Security #: _____ Marital Status:_____

Address: _____

City: _____ State: _____Zip: _____

Home Telephone: _____Work Telephone: _____ Cell_____

Race: _____ Ethnicity _____
Primary Language: _____ Primary Written Language: _____
Employer Name/Address: _____
Emergency Contact: _____Relationship: _____Tel#:_____
How did you hear about this office?_____

INSURANCE INFORMATION

Insurance Company: _____Effective Date of Policy: _____
Policy Number: _____ Group Number: _____
Name of Policy Holder: _____Social Security #:_____

Second Insurance Company (If applicable) _____
Policy Number: _____ Group Number: _____Co-Pay: _____
Name of Policy Holder: _____ Social Security Number: _____
Date of Birth: _____ Sex: M F Relationship to Patient: _____

Is this visit for a work related injury? [ ] Yes [ ] No Auto Accident? [ ] Yes [ ] No
If yes, date of accident/injury: _____
Name of Employer: _____
Name of insurance company.: _____
Address _____
Phone number: _____ Contact Person: _____
Policy/Claim Number: _____ Subscriber: _____

Assignment of Benefits:
I hereby authorize my insurance benefits to be paid directly to Manhan Internal Medicine. I understand that I am financially responsible for any non-covered services, and deductibles, or copayments. I authorized the release of information to specialists as deemed necessary bu my provider. I certify that all of the above information is true and correct

Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Privacy Notice

I acknowledge that I have received a copy of the Manhan Internal Medicine Notice of privacy practices:
Patient Initials: _____

I also authorize the following people to have access to my Protected Health Information:

Name: _____ D.O.B._____ Relation: _____

Name: _____ D.O.B._____ Relation: _____

Name: _____ D.O.B._____ Relation: _____

Name: _____ D.O.B._____ Relation: _____

No Show Policy

Our office will remind you of your appointment 48 hours in advance. If you fail to cancel your appointment and do not show up for your scheduled time you will be charged a $30 no show fee.
Patient Initials: _____

Co-payment Policy

Your co-payment is due upon check-in for your appointment.
Patients Initials:_____

IF COPAYS ARE NOT PAID AT THE TIME OF YOUR APPOINTMENT, AN ADDITIONAL $20.00 WILL BE BILLED TO YOU.

We apologize if this causes any inconvenience.

Patient Signature: _____ Date:_____