DESCHUTES RHEUMATOLOGY

Patient Information

Appointment Date: ____________

Patient: ______________________________ Birthdate: ___/___/___ Gender: F M

Email: ______________________________ Social Security #: ____________

Mailing Address: ______________________ City: __________ State: _______ Zip Code: ________

Home Phone: ______________ Cell Phone: ______________ Ethnicity: ______________

Emergency Contact: ______________________ Relationship: ______________ Phone: ____________

Responsible Party (If Different from Above)

Name: ______________________ Relationship to Patient named above: ______________________

Mailing Address: ______________________ City: __________ State: _______ Zip Code________

Home Phone: ______________ Cell Phone: ______________ Employed By:______________________

Social Security #: ____________ Birthdate: ____/____/____ Gender: F M

Insurance Information:

Medical Insurance: YES OR NO

Name of Primary Insurance Company: ______________________________

Address of Insurance: ______________________________

Phone # of Insurance Company: ______________________________

Subscriber Name: ______________________ ID#: ______________ Group #: __________

Subscriber's Social Security #: ______________ Birthdate: ____/____/____

Do you have Medicare: YES or NO Medicare #______________________

Do you have Secondary Insurance: YES or NO Other insurance Name: ______________________

Assignment and Release:

I have insurance coverage with the organization listed above and assign directly to Deschutes Rheumatology, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not by insurance. I hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorize to use this signature below on all my insurance submissions.

Medicare Authorization:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Deschutes Rheumatology, providers for any services furnished to me by DR providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed: ______________________________ Date: ______________________________