Evansville Multi-Specialty Clinic, PC

PATIENT DEMOGRAPHICS

Please print all information

Date: ______________________ Provider: ____

PATIENT INFORMATION: Email: ________________________________

Name: ____ SSN# ______-______-__________
Last Name First Name Middle Initial

Sex: M F (Circle one) Birth Date ____/____/______ (month day year) Marital Status: Single Married Widow Divorced (circle one)

Address ______________________________ City ____________ State ______ Zip Code ______

Home Ph# ( ) ____________________ Cell Ph# ( ) ______________________

Employer __________________________ Work # ( ) ______________________

Is this worker's compensation? Yes No If yes, please provide the case manager and all needed information prior to visit.

RESPONSIBLE PARTY INFORMATION:

Name: ____ ☐ **SAME AS ABOVE**
Last Name First Name Middle Initial

Birth Date ____/____/_____ SSN# ____-___-______ Relationship to Patient: ________________

Address:________________________ City________________ State______ Zip Code______________

Employer______________________________________ Work Ph# ( ) ________________

EMERGENCY CONTACT INFORMATION:

Name____________________________________ Relation to Patient ______________________

Phone#'s Home ( ) ________________ Work ( ) ________________ Cell ( ) ______________

I consent to the use or disclosure of my protected health information by Evansville Multi-Specialty Clinic, PC. for the purpose of diagnosing or providing treatment to me, obtaining payment from any insurance company, to include, but not limited to, Medicare, Medicare supplement, Medicaid, employer, attorney or their representative to be made directly to Evansville Multi-Specialty Clinic, PC in accordance to federal, state, local and carrier billing regulations and guidelines. In the event my account becomes more than 30 days past due and is referred to a collection agency, I agree to pay collection agency fees, reasonable attorney and/or court costs.

Medical forms are to be completed by billing and/or medical staff and not by the physician. Charges may apply.

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS ARRANGEMENTS HAVE BEEN OTHERWISE MADE PRIOR TO THE APPOINTMENT.

I UNDERSTAND MY CO-PAY IS DUE ON EVERY DATE OF SERVICE. IF UNABLE TO MAKE THE REQUIRED CO-PAY, I MAY BE RESCHEDULED.

Signature of responsible party: ________________________________ **Date:** ______________

If the above signature does not belong to the patient, please list your relationship. ______________