PATIENT INFORMATION SHEET

Facility: Exam time:

Patient:

Last Name	***First Name***	***Middle Name***	***Patient ID***
	Email:		

Sex	***Date of Birth***	*Note: By providing the email address, the patient agrees to receive communication via email from the Health Companion personal health record.*

***Address*:**

Address	***City***	***State***	***Zip Code***

Phone:

Home Phone	***Work Phone***	***Cell Phone***

***Referring Doctor*.**

Physician Name	***Office Phone***	***Office Fax***

***Responsible party*:**

Full Name	***Address: City / State***	***Zip Code***

***Emergency Contact*:**

Name	***Relationship***	***Phone***

***Primary Insurance*:**

Insurance Co. Name	***Plan Number***	***Claims Mailing Address***

Subscriber Name	***Relationship to Patient***	***Subscriber Date of Birth***

***Secondary Insurance*:**

Insurance Co.Name	***Plan Number***	***Claims Mailing Address***

Subscriber Name	***Relationship to Patient***	***Subscriber Date of Birth***

Please sign below and initial next to each statement acknowledging that you have read, understand, and agree to the above:

_____ I authorize direct payment to be made by my insurance carrier to Moran, Rowen, & Dorsey, Inc. for any benefits due me under my insurance plan.

_____ I authorize Moran, Rowen, & Dorsey, Inc. to release to my insurance carrier any medical information necessary to process this claim. I also authorize the release of any medical records for the purpose of healthcare operations.

_____ I understand that my insurance company is being billed for services rendered and I agree that I am financially responsible to pay any charges not covered by my insurance plan as well as any deductibles and coinsurances due.

_____ I understand that pre-authorization may be required for some procedures and it is my responsibility through my referring physician to ensure pre-authorization is obtained prior to my appointment. I agree that I will be financially responsible should my insurance carrier deny my claim, for lack of pre-authorization.

Signature of Patient or Responsible Party: _____ Date: _____

Name of Signer and Relationship to Patient (if other than patient): _____