Carolyn B. Pace, M.D.

How did you hear about our practice:

o Section 1: Patient Demographics Required fields are in Bold print

Patient Name: ______________________ **Date of Birth** ______________ Nickname: ____________

Street Address ______________________ **City** ______________ **State** ____ **Zip** __________

Home Phone ______________ Cell Phone ______________ email: ______________

Gender: θ Female θ Male **Marital Status:** θ Married θ Single θ Other **Patient Social Security** ______________

Employment Status: θ Full time θ Part Time θ Unemployed θ Retired θ Disabled **Employer Name:** ______________

Employer Address ______________________ **Work Phone:** ______________

Student Status: θ Full Time θ Part Time θ Non-Student **If student, School Name:** ______________

Emergency Contact Person ______________ Relationship __________ Phone ______________

Referring Physician Name & Phone: **Primary Care Name & Phone:**

o Section 2: Primary Insurance Plan and Responsible Party Information Required fields are in Bold print

Is your primary insurance Medicare Part B: θ Yes θ No **If yes,** Medicare ID number listed on card: ______________

(If you answered yes to the above question, you do not need to complete any further information in this section. Go to Section 3 if you have secondary insurance coverage).

Insurance Plan Name ______________ **Mailing Address** ______________

City ______________ **State** ____ **Zip** __________ **Phone** ______________

Policy or ID Number: ______________ **Group #** ______________ **Effective Date:** ______________

If the patient is NOT the Insured on the above listed plan, the following information must be completed:

Insured's Name ______________ **Date Of Birth** ______________ **Gender:** θ Female θ Male

Insured's Social Security # ______________ **Relationship to patient:** θ Spouse θ Parent θ Guardian θ Other

Address, <u>if different</u> than patient: ______________ City ______________ State ____ Zip __________

Home Phone ______________ **Work Phone** ______________ **Employer Name:** ______________

o Section 3: Secondary Insurance Information (when applicable) Required fields are in bold print

Insurance Plan Name ______________ **Mailing Address** ______________

City ______________ **State** ____ **Zip** __________ **Phone** ______________

Policy or ID Number: ______________ **Group #** ______________ **Effective Date:** ______________

If the patient is NOT the Insured on the above listed plan, the following information must be completed:

Insured's Name ______________ **Date Of Birth** ______________ **Gender:** θ Female θ Male

Insured's Social Security # ______________ **Relationship to patient:** θ Spouse θ Parent θ Guardian θ Other

Address, <u>if different</u> than patient: ______________ City ______________ State ____ Zip __________

Home Phone ______________ **Work Phone** ______________ **Employer Name:** ______________

o Authorization for Assignment & Release (All patients/guarantors must sign and date this section)

I authorize my insurance benefits to be paid the practice/doctor. I authorize my medical information to be released as required to justify medical necessity on billing documents. I understand and agree to be responsible for any elective or non-covered services that may be provided. I understand that I am financially liable for payment for services rendered and that I am responsible for providing all pertaining insurance information to expedite insurance reimbursement. I agree to pay my required co-pay at the time of service, and agree that if I do not possess current insurance coverage, that I will pay in full for services rendered at the time of service.

Patient/Guarantor Signature ______________________ Date ______________ Time ______

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For Office Use Only Was eligibility performed: ___ Yes ___ No Staff Initials: ______________ Date of First Appointment:

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