

Patient Information Please print and complete all information

Name: _____ Co-Pay Amount: \$ _____
(last) (first) (middle)

Address: _____ City: _____ State: _____ Zip: _____

Sex: _____ Marital Status: Single Married Divorced Widowed

Employment Status: Full Time Part Time Not Employed Self Employed

Retired Active Duty Full Time Student Part Time Student

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____

Responsible Party (if patient is under 18 years of age): _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone #: _____

Relationship to Emergency Contact: _____ Do you have a living will (advance directive)? _____

Insurance Information Complete entire section and provide a copy of your insurance card(s) to registration personnel

Primary Insurance Policy: _____ **I have no insurance**

Policy Holder's Name: _____ Policy Holder's Social Security #: _____

Relationship to patient: _____ Policy Holder's Date of Birth: _____ Phone: _____

Policy Holder's Address (if different from patient): _____
Street City State Zip

Policy/ID#: _____ Group #: _____ Policy Holder's Employer _____

Secondary Insurance Policy: _____ **I have no other insurance**

Policy Holder's Name: _____ Policy Holder's Social Security #: _____

Relationship to patient: _____ Policy Holder's Date of Birth: _____ Phone: _____

Policy Holder's Address (if different from patient): _____
Street City State Zip

Policy/ID#: _____ Group #: _____ Policy Holder's Employer _____

Release of Information:

Who may we release information to other than your insurance company? (IE: spouse, children, power of attorney, etc.)

CONSENT FOR TREATMENT AND FINANCIAL OBLIGATION

I hereby consent to and authorize any examination and administration of all treatments that may be considered advisable and necessary in the judgement of the physician. I understand that insurance cards must be presented each time services are rendered. If I do not present my insurance card, I will be asked to pay privately for services prior to services being rendered. I understand that if my insurance changes, I am obligated to immediately present my new insurance information so that timely claims may be filed on my behalf. Co-payment and non-covered services are due at time of service. I hereby authorize release of information necessary to file a claim to my insurance company and assign benefits otherwise payable to me to Overland Park Family Health Partners, P.A. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

I request that payment of authorized Medicare benefits be made either for me or on my behalf to Overland Park Family Health Partners, P.A. for any services furnished me by a staff physician. 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 benefits or the benefits payable for related services. A copy of this signature is as valid as the original.

Date: ____/____/____

Patient/Responsible Party Signature: _____