Peter J Parker M.D.

Patient Information Sheet

A. TO BE COMPLETED BY PATIENT

Referred by _____ ☐ New Patient Patient No: _____

PERSONAL INFORMATION:

Patient's Name: First _____ M.I. ___ Last _____

Address _____

Sex: ☐ Male ☐ Female Employed: ☐ Yes ☐ No Employer/School _____

Phone: Home (_____)_____-_____ Work (_____)_____-_____

Date of Birth _____ Social Security #:_____-_____ _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Driver License #: _____

Name of person to be contacted in case of emergency _____

Relationship to patient _____ Phone (_____)_____-_____

HEALTH PLAN INFORMATION:

No. of Health Plans: ☐ One ☐ Two ☐ Three

Name of Health Plan _____

Insurance ID No. _____ Group No. _____

Relationship to Insured: ☐ Self ☐ Wife ☐ Husband ☐ Child ☐ Parent ☐ Other _____

Is health plan obtained through the employer? ☐ Yes ☐ No

If insured is other than patient please complete the following:

Insured's Name _____ Social Security #: _____-_____-_____

Sex: ☐ Male ☐ Female Date of Birth _____

Address (if different from the patient) _____

Employer _____ Phone (_____)_____-_____

Patient's Signature _____ Parent of Legal Guardian (if minor) _____

Witness _____ Today's Date _____

B. TO BE COMPLETED BY DOCTORS OFFICE

Type of Plan: ☐ Indemnity Plan ☐ PPO ☐ HMO ☐ POS ☐ IPA ☐ Other : _____

Payor's Name: ☐ As Plan's Name ☐ Other: _____

Eligibility Phone (_____)_____-_____ Effective Date: From ____/____/_____

Mailing Address of Payor: ☐ As card ☐ Other: _____

Is the doctor in the Network? ☐ Yes ☐ No If not, Provider Relations Dept. #: (_____)_____-_____

Individual Deductible For 20___: $_____ Individual Satisfied Amount $_____

Percentage of coverage: ____% Co-pay $_____

Are there any exclusions and/or waivers? ☐ Yes ☐ No; If yes, please indicate _____

Notes: _____

Person Talked To _____ Name _____ Date ____/____/20____