

Welcome to ADVANCED HEALTH CARE

Please complete this form in its entirety

Date _____

PATIENT: This section for patient only:

Name _____ Sex _____ Age _____ Spouse _____
Address _____ SS# _____ DOB ____/____/____
City _____ State _____ Zip _____ Drivers License # _____
Employer _____ Marital Status M S D SEP W
Address _____ Home Phone # _____
City _____ State _____ Zip _____ Work Phone # _____
Nearest Relative or Friend not living with you: _____
Address _____ Phone # _____
How did you hear about our practice? _____

RESPONSIBLE PARTY FOR BILL if other than patient:

Name _____ Relationship to patient _____
Address _____ Employer _____
City _____ State _____ Zip _____ Address _____
SS# _____ DOB ____/____/____ City _____ State _____ Zip _____
Home phone # _____ Work phone # _____

Please Check One:

Private Insurance () Cash () CHAMPUS () MediCal ()
Medicare () HMO () Other ()

PRIMARY Insurance Carrier

Company _____
Address _____
City _____ State _____ Zip _____
Phone # _____
INSURED _____
(name on insurance card)

SECONDARY Insurance Carrier

Company _____
Address _____
City _____ State _____ Zip _____
Phone # _____
INSURED _____
(name on insurance card)

Insured's Relationship to Patient:

Self () Spouse () Child () Other ()

INSURED ID# _____

Group or Plan # _____

Effective Date of Insurance _____

Insured's Relationship to Patient

Self () Spouse () Child () Other ()

INSURED ID# _____

Group or Plan # _____

Effective Date of Insurance _____

Authorization to pay benefits to provider: I hereby authorize payment direct to Advanced Health Care of the Insurance benefits otherwise payable to me, and authorize release of information necessary to process a claim with my insurance company. I hereby accept responsibility for any charges not covered by my insurance, and for missed appointments or cancellations with less than 24 hour notice. A copy of this signature is valid as the original.

Signature _____ Date _____
(if a minor, parent or guardian must sign)

PLEASE COMPLETE THE PROBLEM CHECK LIST !

Office Use Only

Doctor Code _____ Insurance Code _____ DMS III _____
Patient Type Code _____ Referral Code _____ Status/Branch _____

