BELMONT MEDICAL ASSOCIATES

Office use only
Patient internal & external control no:
Name & DOB

Today's Date: _____

PATIENT INFORMATION

Name: _____
Last First Middle Initial/Name

Date of Birth: _____ Age: _____ Gender: M F Social Security No: _____

Race(circle one): African American Asian/Pacific Island Hispanic American Indian/Alaskan Native Caucasian Other _____

Mailing Address: _____
Street (Apt.) City State Zip

____Married _____Single _____Other Employer/School: _____

Are you still working? _____ Yes _____ No Type of Work _____ Hours Worked _____

If you are a student, are you _____ full time or _____ part time? Any eye disease or impaired sight? _____ Yes _____No

Preferred Patient/Family method of communication: Any ear disease or impaired hearing? _____Yes _____No

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

Preferred language: _____ Ethnicity: _____ E-mail address:_____

SPOUSE/PARENT/GUARDIAN INFORMATION

Full Name: _____ Date of Birth: _____ SSN: _____ - ____ - _____

Address: _____ Home Phone: _____

Relationship to Patient: _____ Employer: _____ Work Phone: _____

In case of Emergency, Notify: _____ Phone: _____

INSURANCE INFORMATION

Please present insurance card(s) to Receptionist

Primary Carrier: _____ Secondary Carrier: _____

Policy Holder: _____ Policy Holder: _____

Policy Holder ID No: _____ Policy Holder ID No: _____

Patient relationship to policy holder: _____ Patient relationship to policy holder: _____

Payor ID: _____ Do you have additional health insurance? Yes No

AUTHORIZATIONS

Payment Authorization and Medical Information Release

Financial Responsibility and Assignment of Insurance Benefits: The undersigned guarantees payment to Belmont Medical Associates of all charges for services provided to the patient. I understand that I am responsible for all charges not covered by insurance. I authorize direct payment of surgical and medical benefits, which would otherwise be payable to me, to Belmont Medical Associates for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under title XVIII and XIX of the Social Security Act is correct.

Authorization for Release of Personal and Medical Information: The undersigned authorizes Belmont Medical Associates, its physicians, practices, or agents to disclose any medical and or personal information currently existing or developed during the course of treatment to: 1) the Social Security Administration or its intermediary, which may be needed for or related to a Medicare or Medicaid claim; 2) state or federal agencies that provide benefits and require such information; 3) a referring physician or facility to which a patient may be referred; 4) third party payers or others involved in processing a claim for benefits for services rendered; 5) federal, state or local agencies as required to comply with laws and regulations.

Authorization for Care and/or Treatment: Knowing that I am suffering from a condition requiring health care treatment ("Testament"), I voluntarily consent to such Treatment including diagnostic procedures and medical treatment as ordered by my physician(s). I also voluntarily consent to Treatment provided by assistants, including medical and nursing students and/or other students in medically related fields, as judged necessary by my physician(s). I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations by my caregivers. This form has been explained fully to me and I certify that I understand its contents. Consequently, I hereby release Belmont Medical Associates, its employees, agents, and representatives from such legal responsibilities regarding my knowledge of and consent to medical treatment and from other such legal responsibilities to the extent permitted by law.

_____ (Seal) _____
Patient Signature (or, if Minor, Parent Signature) Date

_____ (Seal) _____
Insured Party or Financial Guarantor (if different from above) Date

Legal Guardian: _____ Date: _____