Jonathan T. Paine M.D., P.A.

PATIENT INFORMATION FORM

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address (Include City, Zip):	Social Security no.:	Home Phone No: ( )

Cell Phone No: ( )	Email:	Referring Physician:

Occupation:	Employer Name & Address:	Employer Phone No: ( )

Language Spoken:

(Circle One) Patient Ethnicity: Hispanic or Latino, Non-Hispanic or Latino

(Circle One) Patient Race: Caucasian, Black or African, Asian, American Indian, Alaska Native, Chinese, Filipino, Japanese, Native Hawaiian, Multiracial, Pacific Islander.

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate Primary Insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable): (If Medicare is Secondary, Please Indicate why):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

On the Job Injury: ❑ Yes ❑No	Auto Injury: ❑ Yes ❑No	Date of Accident:	Attorney Involved: ❑ Yes ❑No

Please Notify Receptionist if YES to any of the above.

Brief Description of Accident:

If on the job injury, name of Adjuster:

If Attorney is involved, name of Attorney:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Patient's Name: _____

Medical Surrogate or Advance Care Plan (Living Will)

Do you have a medical surrogate (person you have designated to make medical decisions for you if you are incapacitated)? If so, please list surrogate's name and contact information

_____ _____

Name Relationship

_____

Address Line 1

_____ _____

Address Line 2 Phone

Do you have an advance care plan (living will)? If so, please provide a copy to this office.

Assignment of Benefits

I assign the right to payment for all medical benefits directly to Jonathan T. Paine, M.D., P.A. in consideration for medical services and supplies provided pursuant to my health insurance plan.

In the event my health insurance plan refuses to pay for provided, medically necessary services, I also assign all my ERISA* rights to Jonathan T. Paine, M.D., P.A. for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for faulty claims processing. This ERISA assignment is in consideration for the unpaid services provided and in consideration for the continued willingness of Jonathan T. Paine, M.D., P.A. to see patients, including myself on an insurance assignment basis. I understand that if my treating doctor prevails in any such payment dispute, I may be liable for co-payment for the contested services.

I give consent to release medical information to Jonathan T. Paine, M.D. I give consent to Jonathan T. Paine, M.D., P.A. to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to Jonathan T. Paine, M.D. to send medical information as necessary, to my insurance plan.

_____ _____

Date Signature

*ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts up to $110 a day for each infraction.

LIFETIME SIGNATURE AUTHORIZATION:

This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned for services beginning:

_____ _____

Date Signature