PATIENT _____
last first middle

Address _____
street city state zip county

Home Phone _____ Phone # during the day _____ Sex M ____ F ___

Birthdate _____ - _____ - _____ Race _____ Age ____ SS# _____ - _____ - _____ Married: Y__ N__

Employer or School _____
name & address

_____
phone number job title full or part time

Parent or Spouse: _____ Parent or Spouse's SS# _____ - _____ - _____ Birthdate _____
first & last name

Parent or Spouse's Employer _____
name & address phone number

GUARANTOR _____
last first middle

Address _____
street city state zip county

Phone _____ SS# _____ - _____ - _____ Relationship to Patient _____

Employer _____
name & address phone number

Nearest Relative Not Living With Patient - Name _____

Address _____
street city state zip county

Phone _____ Relationship to Patient _____

Please bring the following with you to every doctor's visit:

- Your most recent insurance card.
- Your co-pay, if you have one.
- A list of ALL current medicines you are taking.
- If you have a deductible or HSA plan, you will be asked to pay the % amount due from you **at the time of visit**.

Sellersburg Internal Medicine and Pediatrics

Please understand that failure to do any of the above may result in your appointment being rescheduled for another day or time.

I hereby grant permission to Sellersburg Internal Medicine & Pediatrics (SIMP) to administer medication and/or perform needed medical treatment. I hereby assign all benefits payable to SIMP and understand that the balance not paid by my insurance company and/or predetermined to not be covered by my insurance company will be my responsibility.

Signed (patient) _____ Date _____

Signed (guarantor) _____ Date _____

MEDICARE PATIENTS - I authorize any holder of medical or other information about me to release to the Social Security Administration and HCFA or its intermediaries or carrier of any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of benefits to SIMP. Regulations pertaining to Medicare assignment of benefits apply.

Signed (patient) _____ Date _____