

PREMIER INTERNISTS

Division of Millennium Medical Group

Single
Married
Widowed
Divorced

Date: _____ Sex: male ___ female ___ Age: ___ Birth date: _____

Name: _____
(Last) (First) (Middle)Address: _____
(Number) (Street) (City) (State) (Zip Code)

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Social Security Number: _____ Insurance: _____

Referred to Doctor by: _____ Patients Occupation: _____

If employed, by whom: _____ Business Phone Number: _____

Spouse's Full Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

I certify that I, and/or my dependants have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the release to the centers for Medicare and Medicaid services, my Medigap insurer and their agents any information needed to determine these benefits.

Patient Signature: _____ Date: _____

Parent or guardian Signature: _____ Date: _____