

Welcome To Our Office

NEW PATIENT INFORMATION

Patient S.S. #		Drivers License #	
Last Name		First Name	MI
Gender M () F ()			
Date of Birth		Marital Status: S () M () W () D ()	
Patient's Address:			
City		State	Zip
Home # () -		Work # () -	Cell () -
Email Address:			
Responsible Party S.S. #		Drivers License #	
Last Name		First Name	MI
Gender M () F ()			
Date of Birth		Marital Status: S () M () W () D ()	
Patient's Address:			
City		State	Zip
Home # () -		Work # () -	Cell () -
Insurance Information			
Name of Primary Insurance			
Patient's Relationship to Insured: Self () Spouse () Child () Other ()			
Name of Insured (Subscriber)		Date of Birth	
Subscriber S.S.#			
Subscriber's Employer			
Policy Number		Group #	
Co-Pay Amount		Effective Date	
Name of Secondary Insurance			
Patient's Relationship to Insured			
Name of Insured (Subscriber)		Date of Birth	
Subscriber S.S.#			
Subscriber's Employer			
Policy Number		Group #	
Co-Pay Amount		Effective Date	

I request that payment of authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to The Columbus Clinic for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Acknowledgement of Receipt of Privacy Notice-I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and, subject to the following restriction(s) concerning my personal medical information. I agree to the disclosures named in the notice.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Signature of Policy Holder _____ Date _____