



MFM Patient Information Form

Patient Name: _____
Last First M.I.

Current Address:
Street: _____
PO Box / Apt #: _____
City, State: _____ Zip: _____

Permanent Address, if different:
Street: _____
PO Box / Apt #: _____
City, State: _____ Zip: _____

Date of Birth: ____/____/____ **Gender:** M / F
Month Day Year

Personal Phone #: (____) _____ - _____

Soc Sec #: _____ - _____ - _____

Work Phone #: (____) _____ - _____

eMail Address: _____

Is Patient Employed or a Student? Employed Full-time Student Part-time Student No

If so, Company/School Name: _____
Address: _____
Student ID#: _____

Marital Status: S M W D
Spouse's Name _____

Date of Birth: ____/____/____
Month Day Year

Students & Minors:

Father's Name: _____
Address: _____
Home Phone: (____) _____ - _____
Work Phone: (____) _____ - _____
Employer: _____

Mother's Name: _____
Address: _____
Home Phone: (____) _____ - _____
Work Phone: (____) _____ - _____
Employer: _____

Primary Insurance Name: _____
Ins. Co. Address: _____
City, State: _____ Zip: _____

Secondary Insurance Name: _____
Ins. Co. Address: _____
City, State: _____ Zip: _____

Policyholder: _____
Policy #: _____
Group #: _____
Date of Birth: ____/____/____ SSN#: _____
Gender: M / F
Home Address: _____
City, State: _____ Zip: _____
Home Phone: (____) _____ - _____
Employer: _____

Policyholder: _____
Policy #: _____
Group #: _____
Date of Birth: ____/____/____ SSN#: _____
Gender: M / F
Home Address: _____
City, State: _____ Zip: _____
Home Phone: (____) _____ - _____
Employer: _____

I have completed this form accurately to the best of my knowledge and certify that I am the above-named patient or the duly authorized general agent of the above-named patient, authorized to furnish the information requested, and seek and authorize health care services. I understand that, even though I may have insurance coverage, I am responsible for payment for all services rendered. I authorize the release of any medical information necessary to process my insurance claim. I also request payment of all insurance medical benefits to Moscow Family Medicine, PA for services provided to the above-named person.

If I have Medicare or if, in the future, I seek services to be paid under the auspices of the Medicare program, I request that payment of authorized Medicare benefits be made either to me on my behalf or to Moscow Family Medicine, PA for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or these benefits payable to related services. I understand that my signature requests that payment be made, and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature

Date