



## PATIENT INFORMATION FORM

### PATIENT INFORMATION

NAME (FIRST, MIDDLE, LAST)		SEX	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER
PERMANENT ADDRESS (STREET & APARTMENT NUMBER)			TEMPORARY ADDRESS, IF ANY (STREET & APARTMENT NUMBER)	
PERMANENT ADDRESS (CITY, STATE & ZIP)			TEMPORARY ADDRESS, IF ANY (CITY, STATE & ZIP)	
PERMANENT HOME PHONE NUMBER (INCLUDE AREA CODE) ( ) - Ext.		TEMPORARY HOME PHONE NUMBER, IF ANY (INCLUDE AREA CODE) ( ) - Ext.		
LANDLORD'S PHONE NUMBER (IF RENTING) ( ) - Ext.	AGE	NAME / ADDRESS FOR NON-CUSTODIAL PARENT		
WORK PHONE NUMBER (INCLUDE AREA CODE) ( ) - Ext.		MINOR'S FATHER'S NAME / SOCIAL SECURITY NUMBER / DATE OF BIRTH		
OCCUPATION		MINOR'S MOTHER'S NAME / SOCIAL SECURITY NUMBER / DATE OF BIRTH		
PREVIOUS PHYSICIAN, ADDRESS & PHONE NUMBER ( ) - Ext.		EMPLOYER		
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		EMPLOYER'S ADDRESS / PHONE NUMBER ( ) - Ext.		
EMERGENCY CONTACT	PHONE NUMBER ( ) -	HOW WERE YOU REFERRED TO OUR PRACTICE? <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> FRIEND <input type="checkbox"/> RADIO <input type="checkbox"/> TV <input type="checkbox"/> THEATER <input type="checkbox"/> PHONE BOOK <input type="checkbox"/> INSURANCE <input type="checkbox"/> OTHER _____		

### INSURANCE INFORMATION

NAME OF POLICYHOLDER (FIRST, MIDDLE, LAST)		SEX	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER
PERMANENT ADDRESS (STREET & APARTMENT NUMBER)			NAME OF INSURANCE (IF YOU HAVE TWO, LIST BOTH) 1.)	
PERMANENT ADDRESS (CITY, STATE & ZIP)			2.)	
PERMANENT HOME PHONE NUMBER (INCLUDE AREA CODE) ( ) - Ext.		TYPE OF POLICY (HMO, PPO, STANDARD INDEMNITY) 1.)		
PATIENT RELATIONSHIP TO INSURED		2.)		
LANDLORD'S PHONE NUMBER (IF RENTING) ( ) - Ext.		PATIENT'S I.D. NUMBER 1.)		
CURRENT PCP (AS LISTED ON CARD)		2.)		
OCCUPATION		GROUP NUMBER 1.)		
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		2.)		
NEAREST RELATIVE NOT LIVING WITH YOU		EMPLOYER		
RELATIVE'S PHONE NUMBER (INCLUDE AREA CODE) ( ) - Ext.		EMPLOYER'S ADDRESS / PHONE NUMBER		
NEAREST FRIEND NOT LIVING WITH YOU		( ) - Ext.		
FRIEND'S PHONE NUMBER (INCLUDE AREA CODE) ( ) - Ext.		SPOUSE'S EMPLOYER / WORK PHONE NUMBER ( ) - Ext.		
WILL BE PAYING TODAY WITH <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> EXTENDED PAYMENT (APPROVAL REQUIRED)				

*I understand and agree that I am ultimately responsible for payment.  
I certify that this information is true and correct to the best of my knowledge.*

Signature of Person Financially Responsible

Date

Accepted by

**PATIENT INFORMATION**

Welcome to Nova Medical Group. It is to our mutual benefit that our patients understand our Payment Policy. We make every effort to keep the cost of your medical care to a minimum. Due to the expense of processing insurance claims, we request full payment at the time of your visit. If your insurance company is one with which we participate, we will bill your insurance company as agreed between Nova Medical & Urgent Care Center Inc. and the respective insurance company. Ultimately, responsibility for payment lies with the patient. Payment not received from the insurance company within 45 days becomes the responsibility of the patient. Please sign the following authorization so that payment may be made to Nova Medical Group for services rendered and billed by Nova Medical & Urgent Care Center Inc.

Patient: \_\_\_\_\_

Address: \_\_\_\_\_

**OUR PAYMENT POLICY**

I, the undersigned, hereby authorize Nova Medical & Urgent Care Center Inc. to apply for benefits on my behalf for covered services rendered to me, not paid in full today.

I REQUEST PAYMENT FROM MY INSURANCE CARRIER, IF ANY, BE MADE DIRECTLY TO NOVA MEDICAL GROUP UNLESS OTHERWISE INDICATED ON THE CLAIM.

I certify that the information reported with regard to insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claim, to the insurance carrier. In making this assignment, I understand and agree that I am financially responsible for changes not paid under this insurance policy.

**RELEASE INFORMATION**

Nova Medical Group may disclose any or part of this medical record to my insurance company (or companies) for purposes of satisfying charges billed. I further understand that it may be necessary to contact my past or present employer(s) in regard to the insurance claim.

**GUARANTEE OF PAYMENT**

To Nova Medical Group: For and in consideration of services rendered, or to be rendered to the above named patient. I guarantee payment of all said charges incurred in accordance with the policy of payment of bills. Interest on the unpaid balance at the rate of eighteen percent (18%) per annum will be accrued 45 days after services rendered. In the event the account must be placed with an attorney or collection agency to obtain payment, I shall be responsible for all attorney and collection agency fees incurred.

**THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS**

\_\_\_\_\_  
Signature of Person Financially Responsible

\_\_\_\_\_  
Witness

Date: \_\_\_\_\_

Address (If other than patient's): \_\_\_\_\_

\_\_\_\_\_