

NORTH SHORE MEDICAL GROUP
PATIENT INFORMATION

PATIENT NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY #: _____ SEX: M _____ OR F _____

BIRTH DATE: ____/____/____ MARITAL STATUS: _____

CURRENT EMPLOYER: _____ WORK PHONE: _____

IN CASE OF EMERGENCY, WHO SHOULD WE NOTIFY: _____

RELATIONSHIP: _____ HOME PHONE: _____ WORK PHONE: _____

PRIMARY INSURANCE CO: _____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDERS ID# _____ POLICY HOLDERS GROUP# _____

POLICY HOLDERS SOC SEC #: _____ POLICY HOLDERS DATE OF BIRTH _____

SECONDARY INSURANCE CO: _____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT _____

POLICY HOLDERS ID# _____ POLICY HOLDERS GROUP# _____

POLICY HOLDERS SOC. SEC. #: _____ POLICY HOLDERS DATE OF BIRTH _____

I ASSIGN NORTH SHORE MEDICAL GROUP ALL RIGHTS, PRIVILEGES AND INTERESTS IN ALL OF MY HEALTH INSURANCE POLICIES, THEREBY AUTHORIZING NORTH SHORE MEDICAL GROUP TO ACCEPT ASSIGNMENT OF BENEFITS AND FILE INSURANCE CLAIMS FOR THE COST OF ANY SERVICES RENDERED.

I UNDERSTAND THAT SAID BENEFITS ARE NOT A GUARANTEE OF PAYMENT AND THAT I AM RESPONSIBLE FOR THE ENTIRE BILL, INCLUDING ANY DEDUCTIBLES AND CHARGES INCURRED NOT COVERED BY MY INSURANCE CARRIER.

I ALLOW NORTH SHORE MEDICAL GROUP THE RIGHT TO RELEASE MEDICAL INFORMATION, MEDICAL RECORDS, AND PROVIDE CLINICAL DATA TO MY INSURANCE COMPANY AND CONSULTING PHYSICIANS. I AUTHORIZE NORTH SHORE MEDICAL GROUP TO CONTACT MY INSURANCE CARRIER IN ORDER TO FACILITATE PAYMENT.

SIGNATURE OF PATIENT: _____ DATE: _____