Central Ohio Primary Care Physicians, Inc

PATIENT INFORMATION **TODAY'S DATE**

Name____ Sex___DOB __/__/___ Age___

Address____ Phone(___)_________________

City________________________State_________Zip___________SS#______________________

Employer____ Phone(___)________________

Driver License Number/State____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name_____________

Referred By________________________________ **Allergies**___________________________

Nearest Relative (EMERGENCY CONTACT) Other than Spouse

Name_______________________ Relationship_____________ Phone(___)____________________

Address_____________________ City____________________ State _________ Zip____________

Insurance Information

Primary Insurance Company____________________________ Phone (___)___________________

Policy #__________________Insured's Name___________________ Sex ___DOB __/__/__ Age__

Secondary Insurance Company__________________________Phone (___)___________________

Policy #__________________Insured's Name___________________ Sex ___DOB __/__/__ Age__

INSURANCE PAYMENT CONSENT

I understand that my insurance carrier can choose to assign benefits to Central Ohio Primary Care Physicians or my insurance carrier may make payment directly to me. I understand and certify that I am financially responsible for all health care service charges that are paid to me directly by my insurance carrier, as well as for any applicable co-payment, co-insurance, deductible, or charges for non-covered services provided to me or to any of my dependents. I am also responsible for providing up to date accurate insurance information.

Medicare and Medicaid I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of Medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, or its intermediaries or carriers any and all information needed for this or a related Medicare or Medicaid claim.

By signing below, I certify that I will pay to Central Ohio Primary Care Physicians, any co-payments, co-insurance, deductibles, or non-covered services. I will immediately pay to Central Ohio Primary Care Physicians any payments that I receive from my insurance company for services provided to me or my dependents. I will also be responsible for any amounts not paid by insurance for my failure to provide the appropriate insurance information for billing.

Name____ Date____________________
(Printed)

Signature_____________________________________ __________ Witness______________________
(If patient is 18 years or older, his/her signature is required in addition to the responsible party)