



CENTRAL OHIO
PRIMARY CARE

PATIENT INFORMATION Instructions: Complete the form and bring it to your appointment			TODAY'S DATE	
Name	Sex: (circle one) M F	DOB:	Age:	
Address:	Phone <i>primary</i> : ()		Phone <i>alternate</i> : ()	
City:	State:	Zip:	SS#	
Employer:			Ph:	
Marital Status: S M D W	Spouse Name:			
REFERRED BY:	ALLERGIES:			
NEAREST RELATIVE (EMERGENCY CONTACT) OTHER THAN SPOUSE:				
Name	Relationship:		Ph:	
Address:	City:	State:	Zip:	
INSURANCE INFORMATION:				
Primary Insurance Co.		Insured SS#		
Insured's Name	Sex: M F	DOB:		
Secondary Insurance Co.:		Insured's SS#		
Insured's Name:	Sex M F	DOB		

Please present your insurance cards at every appointment. To submit a claim to your insurance company, we will need complete and accurate insurance information. Thank you.

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

All other Insurance companies and/or third party payers: I hereby authorize Central Ohio Primary Care Physicians, Inc. and/or any of its representatives to submit a claim to my insurance carrier or its intermediaries to issue payment directly to Center Ohio Primary Care Physicians, Inc. and or physicians(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

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 it to the Social Security Administration, Medicare, Medicaid or its intermediaries or carriers any and all information for this or related Medicare or Medicaid claim. I authorize and request that payment be made directly to Central Ohio Primary Care Physicians, Inc. **Guarantee of Payment:** I UNDERSTAND that filing a claim with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Central Ohio Primary Care Physicians, Inc to me or the patient as indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to claims filed for Worker's Compensation and/or claims due to personal injury, accidents or illnesses.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

PATIENT SIGNATURE:

DATE:

(If patient is 18 years or older, his/her signature is required, in addition to the "responsible party".

RESPONSIBLE PARTY:

DATE:

(if other than patient)