PATIENT INFORMATION SHEET

PATIENT NAME ____ **SEX: M F**
(LAST) (FIRST) (MIDDLE)

ADDRESS ____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE ______________________ **ALTERNATE / CELL #** ______________________
☐ OK TO LEAVE MESSAGE WITH DETAILED INFORMATION
☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

MARITAL STATUS S M W D

SOCIAL SECURITY # ______________________ **BIRTHDATE** ______________ **AGE** __________

EMPLOYER ______________________ **EMPLOYER'S PHONE #** ______________________
☐ OK TO LEAVE MESSAGE WITH DETAILED INFORMATION
☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

EMAIL ADDRESS______________________ PHARMACY______________________

PHARMACY ADDRESS______________________________PHONE______________________

Language spoken:________________Race:________________Ethnicity:________________
(Please enter NA if you do not want to answer the above three questions.)

SPOUSE or PRIMARY INSURED INFORMATION

NAME ____
(LAST) (FIRST) (MIDDLE)

BIRTHDATE ______________________ **SOCIAL SECURITY #** ______________________

EMPLOYER ______________________ **EMPLOYER'S PHONE #** ______________________

Phone number if different from yours: ______________________________

PHYSICIAN WHO SENT YOU TO US ______________________________

ADDRESS / PHONE # ______________________________

FAMILY PHYSICIAN ______________________________

ADDRESS / PHONE # ______________________________

EMERGENCY CONTACT

NAME OF PERSON NOT LIVING WITH YOU ______________________________

RELATIONSHIP ______________________ PHONE # ______________________

INSURANCE INFORMATION

Our practice participates with most insurance companies. If you have an HMO policy, it is your responsibility to have referral information with you. Physician assistants (PA's) and nurse practitioners (NP's) employed by MidAmerica Heart and Lung Surgeons will be helping with your surgical procedure and recovery. Separate charges will be submitted for their services. All charges are submitted to your insurance carrier for payment. **However, the patient is responsible for surgeon, PA and NP charges not paid by insurance. Your insurance might not cover these charges.** Ultimately, it is the patient's responsibility to contact their insurance carrier to determine the benefits their plan provides.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES NOT PAID BY INSURANCE. IT IS ALSO CUSTOMARY TO PAY COPAYS AND/OR DEDUCTIBLES AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WTH OUR BILLING DEPARTMENT. FAILURE TO NOTIFY OUR OFFICE IN ADVANCE CONCERNING ANY CHANGE OR CANCELLATION IN YOUR INSURANCE COVERAGE WILL MAKE YOU FINANCIALLY RESPONSIBLE FOR ANY INCURRED CHARGES AFTER SUCH CHANGE GOES INTO EFFECT.

PRIMARY INSURANCE____

CLAIMS MAILING ADDRESS ____

POLICY #______________________________ GROUP # ______________________________

NAME OF POLICY HOLDER ___________________________ BIRTHDATE_______________

POLICY HOLDER SSN# ______________________ RELATIONSHIP______________________

SECONDARY INSURANCE____

CLAIMS MAILING ADDRESS ____

POLICY #______________________________ GROUP # ______________________________

NAME OF POLICY HOLDER ___________________________ BIRTHDATE_______________

POLICY HOLDER SSN# ______________________ RELATIONSHIP______________________

MEDICARE, MEDICAID, AND COMMERCIAL LIFETIME ONE CONSENT AGREEMENT: I request that payment under the medical insurance program be made to MidAmerica Heart and Lung Surgeons on any service furnished me by these physicians. I further authorize the release of necessary medical records information to any carrier listed on the claim for the purposes of processing any Medicare, Medicaid or Commercial insurance claim. I also authorize the release of my medical records to any insurance company requesting this information regarding my medical status for the purposes of applying for health or life insurance, or in the event that this information would be needed to process my claim for medical or disability benefits.

I also understand that I am financially responsible for all charges not covered by insurance.

I authorize my medical records from any healthcare facility be released to MidAmerica Heart and Lung Surgeons in order to assist in my care.

Signed____ Date ____________________

Patient or Authorized Person's Signature