

SOUTHDALE INTERNAL MEDICINE

PATIENT INFORMATION

NAME _____ SPOUSE _____
(First Name MI Last Name)

ADDRESS _____ SPOUSE DOB _____

CITY _____ STATE _____ ZIP _____
MALE OR FEMALE

HOME PHONE (_____) _____ BIRTHDATE _____ AGE _____

SOCIAL SECURITY NUMBER _____

SPOUSE SOCIAL SECURITY NUMBER _____

PLEASE CIRCLE ONE:	
SINGLE	MARRIED
WIDOWED	DIVORCED

PATIENT EMPLOYER _____ WORK PHONE (_____) _____

SPOUSE EMPLOYER _____ WORK PHONE (_____) _____

PRIMARY INSURANCE _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

POLICY NUMBER(S) _____
(Identification #) (Group / Plan #)

SECONDARY INSURANCE _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

POLICY NUMBER(S) _____
(Identification #) (Group / Plan #)

I hereby authorize SOUTHDALE INTERNAL MEDICINE to furnish information concerning my illness and treatments to INSURANCE CARRIERS and PHYSICIANS directly involved in my care. I authorize payment of any medical benefits to SOUTHDALE INTERNAL MEDICINE I certify that the above information is correct and that I am responsible for payment of services rendered. I permit a copy of this authorization to be used in place of the original.

DATE _____ SIGNATURE: X _____

MEDICARE AUTHORIZATION: I request that payment of authorized medical benefits be made on my behalf to SOUTHDALE INTERNAL MEDICINE for services furnished me by this clinic/physician/supplier. I authorize any holder of hospital or medical information about me be released to the HEALTH CARE FINANCING ADMINISTRATION and it's agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

DATE _____ SIGNATURE: X _____

THANK YOU FOR CHOOSING SOUTHDALE INTERNAL MEDICINE