Brookridge Internal Medicine Associates, PA

PLEASE BRING INSURANCE CARD, DRIVERS LICENSE AND MEDICATIONS TO YOUR APPOINTMENT.

PATIENT INFORMATION

Name_____ Date of Birth _____ Age_____
Address_____City_____State_____Zip_____
Primary/cell phone# _____Work #_____Home # _____

Sex: M F SS # _____ Drivers License # _____

Ethnicity: ___Hispanic ___Not Hispanic Race: __White __African American ___Other

Email address _____

Last Primary Care Physician_____ Phone _____

EMPLOYER INFORMATION

Employer_____ Phone_____
Address_____City_____State_____Zip_____
May we contact you at work? **Yes_____ No_____**

INSURANCE INFORMATION

Insurance Company Name_____ Phone_____
ID Number _____ Group # _____

Secondary Insurance Information
Insurance Company Name _____
ID Number _____Group # _____Subscriber DOB_____

EMERGENCY CONTACT

Name_____Relationship_____Phone_____
Address _____City _____State_____ Zip _____

Medical Power of Attorney (person to make decisions if you can't)

Name:_____ Phone # _____

Please be advised that you are ultimately responsible for the payment of services rendered to you. By signing below, you authorize direct payment of medical benefits to Brookridge Internal Medicine Associates, P.A. for services rendered and that you are financially responsible for any balance not covered by your insurance and for payment in full due to non-payment of health insurance premiums. Also, by signing below you authorize Brookridge Internal Medicine Associates, P.A. to release any medical or incidental information that may be necessary for either medical or processing applications for financial benefit.

X

SIGNATURE OF PATIENT/GUARDIAN **DATE**