# PATIENT INFORMATION SHEET

Last Name ______ First Name ______ Middle Initial ______

Address ______

City ______ State ______ Zip ______

Telephone #: ______ Alternate or Cell # ______

Sex M F ______ Marital Status ______ Date of Birth ______

Social Security # ______ If Applicable: Height ______ Weight ______

Employer ______ Phone # ______

Referring Physician ______ Phone # ______

## IF WORK RELATED INJURY PLEASE COMPLETE THIS SECTION

Claim # ______ Date of Injury ______

Employer at time of injury ______ Phone # ______

MCO ______

## INSURANCE INFORMATION

Primary Insurance ______

Card Holder for this Insurance ______

Card Holder's DOB: ______ SS# ______

Employer ______ Phone # ______

Secondary Insurance ______ DOB: ______

Card Holder for this Insurance ______

I request that payment of authorized Medicare or insurance benefits be made either to me or on my behalf to **Advanced Medical Supply** for any services furnished me by this facility. I authorize any holder of medical information about me to release to the Centers for Medicare, Medicaid or other insurance services and its agents any information needed to determine these benefits or the benefits payable related services to release any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. I also understand that I am financially responsible for payment of services provided. I also acknowledge that I have received a copy of the HIPAA Privacy Practices, a copy of the Patients Rights Policy and Medicare supplier standards if applicable.

**SIGNED** ______ **DATE** ______