ima | Healthcare
Internal Medicine Associates

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Patient Information

Name of Patient: _____ _____ _____ Date of Birth:_____
(Last) (First) (MI)

Address: _____ City: _____ State: _____ Zip Code: _____

SSN: _____-_____-_____ Male Female Marital Status: _____
(Please Circle)

Phone: (Home) _____ (Cell) _____ (Work) _____

Email: _____

Insurance

(We will take a copy of your card)

Name: (if different) _____

Primary: _____ Work Comp: _____

Important Information:

Please Read Carefully

1. I, the patient, and/or head of household do authorize any holder of medical information about me to release to my insurance providers any information needed to determine the benefits payable for related services.

2. I request that payment of authorized insurance or Medicare benefits be services furnished to me by this clinic.

3. I understand and agree that I will be responsible for the payment of any services not covered by payments from any insurance companies or other third parties.

I have received a copy of the HIPAA Notice of Privacy Practices

Signature of Patient: _____ Date: _____

Signature of Guardian (patient unable to sign): _____ Date: _____