2015 Patient Information Sheet - Skyline Internal Medicine

Who is your physician? ☐ Dr. Ghincea ☐ Dr. Havlen ☐ Dr. Schultz ☐ Dr. Sebestyen New Patient? ☐ Y ☐ N

Patient Name_____ **Prefer to be called:** _____
First Name Middle Initial Last Name

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

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

SSN: _____ **Marital Status:** _____ **Date of Birth**_____ **Gender: ☐ F ☐ M**

Employers Name: _____ **Occupation:** _____

New Patients to the Practice: **Who may we thank for your referral to our practice? Please check one:**

Referred by : ☐ Dr. (_____) ☐ Family Member ☐ Friend ☐ Insurance Directory ☐ Mailer ☐ Our Website

☐ Other (Please Specify): _____

HEALTH INSURANCE INFORMATION - OR - SELF PAY

(Although we have copied your insurance card, we will need you to complete all of the information below)

PRIMARY INS: _____ **Eff. Date:** _____ **Copay Amt.: $**_____

Policy Holder Name: _____ **DOB:** _____ **M / F:** _____

If same as above, please write "same" on this line & disregard the primary insurance section

Policy Holder Address (if different from above): _____

Policy Holder Employer: _____ **Employer Ph#: (___)** _____

Relationship to Policy Holder: _____ **Policy Holder SS#:** _____

Policy Holder ID: _____ **Group #:** _____

Secondary INS: _____ **(if Medicare is 2ndary, please read below) EFf. Date:** _____

Medicare Patient's Only: If Medicare is your secondary insurance, please list a reaons why Medicare is the secondary insurance. Information needed in order to file your claim with Medicare. Reason: _____

Policy Holder Address (if different from above): _____

Policy Holder Employer: _____ **Employer Ph#: (___)** _____

Relationship to Policy Holder: _____ **Policy Holder SS#:** _____

Policy Holder ID: _____ **Group #:** _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ **Relationship to Patient:** _____

Home Ph#: _____ **Work Ph:** _____**Alt. Ph#**_____

Do you have a living will or a durable power of attorney? (circle one) Yes No

****If yes, please provide the office a copy****

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. **I authorize HealthONE / Skyline Internal Medicine to render needed treatment to the above named patient.**
2. **I authorize HealthONE / Skyline Internal Medicine to release any information required for payment of claims.**
3. **I authorize my insurance benefits to be paid directly to the treating physicians, realizing I am responsible to pay non-covered and unauthorized services and I hereby authorize the release of pertinent medical information to insurance carrier.**
4. **I understand that I am responsible for all charges incurred through HealthONE / Skyline Internal Medicine. Payment is expected at the time of my visit.**

Email Address: _____ **☐ NO EMAIL**

Patient/Responsible Party Signature: _____ **Date:** _____