Williamstown
MEDICAL
Associates

Serving the Community Since 1958

Appointment Date _____

PURPOSE: Your accurate answers to the following questions will assist our personnel in preparing your clinical records. Answers to these questions will be part of your permanent confidential medical records.

PLEASE COMPLETE ALL THE BLANKS

(Circle) Mr./Mrs.
Full Name Miss _____ Date of Birth _____
Address _____ Phone ( ) _____
Street City & State Zip
E-Mail Address _____
Place of Birth _____ Occupation _____
Employed by _____ SS# _____
Employer's Address _____ Bus. Phone ( ) _____
Nearest Relative's Name
(other than spouse) _____ Phone ( ) _____
Address _____
Name of Spouse or
Responsible Party _____ Phone ( ) _____
Address _____
Spouse's Employer _____ Phone ( ) _____
Address _____

Yes – No If Yes, Previous Name(s)?
Who Referred You for Your Visit Today? _____
Have You Ever Changed Your Name?_____
In Case of Emergency, Contact _____ Relationship _____
Address _____ Phone ( ) _____

INSURANCE INFORMATION

Medicare No. _____ Effective Date _____ Medex No. _____ Eff. Date _____

Blue Shield Policy No. _____ Group No. _____ State _____
Effective Date _____ Subscriber _____ Relationship _____

Medicaid Card No. (10 Digit) _____ Sequence No. (2 Digit) _____ Effective Date _____
ID. No. _____

OTHER INSURANCE
Insurance Carrier _____ Policy No. _____
Address _____
In Whose Name is Policy Issues _____ Relationship _____
Address _____

SEE OTHER SIDE

PREPAID INSURANCE (HMO, PPO)

Plan Name _____ Patient's Plan No. _____ Name of Primary Doctor _____

Medicare Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Authority, or its intermediaries or carriers, any information needed for this and all subsequent Medicare claims for service rendered to me. I permit a copy of this authorization to be used in place of the original.

_____ _____

Date Signed Patient's Signature

Medicare Supplemental Insurance Authorization

I authorize the Williamstown Medical Associates to file insurance claims on my behalf of the company(ies) with which I have coverage. I also permit the release of medical or other information about me which may be required for filing such claims. I permit a copy of this authorization to be used in place of the original.

I request that payment under the medical insurance program(s) be made to me or the Williamstown Medical Associates on any bills for services rendered to me by the group and its professional staff, for as long as I continue to receive services from the Williamstown Medical Associates.

_____ _____

Date Signed Name of Supplemental Insurance Carrier

_____

Patient's Signature

Insurance Authorization

I authorize the Williamstown Medical Associates to file insurance claims on my behalf of the company(ies) with which I have coverage. I also permit the release of medical or other information about me which may be required for filing such claims. I permit a copy of this authorization to be used in place of the original.

I request that payment under the medical insurance program(s) be made to me or the Williamstown Medical Associates on any bills for services rendered to me by the group and its professional staff, for as long as I continue to receive services from the Williamstown Medical Associates.

_____ _____

Date Signed Patient or Guardian Signature

If The Above Is Not Applicable, Please Sign for Signature Identification.

_____ _____

Date Signed Patient or Guardian Signature