ID Doctors, PA

Infectious Disease Doctors, P.A.

Patient Information

Please Print

Name: _____ Date: _____
Date of Birth: _____ SS#:_____
Address:_____
_____
City : _____ State: _____ Zip: _____
Home Phone:_____ Cell/Pager:_____
Marital Status: Single___ Married ___ Divorced ____ Widowed ____ Other _____
Emergency Contact *(**Not** living with you)*:
Name: _____ Phone: _____Relationship:_____
Referring Physician:_____Phone: _____
Primary Physician:_____ Phone: _____

Employment Information of Insured

Job Title : _____ Full Time____ Part Time_____ Student_____
Employer or School Name:
_____
Employer Address:_____ City:_____ State: _____ Zip:_____

Employer Phone _____ Is your condition job related? Yes / no

Primary Insurance Information

Insurance:_____
HMO/PPO/POS/EPO/WC/Indemnity/Cobra
Address:_____City: _____ State: _____ Zip: _____
Phone: _____ ID#:_____Group: _____

Relationship to Insured – (circle one) Self Spouse Child Other
Policy Holder Name: _____DOB:_____SS#::_____
Address: _____ City: _____State: _____Zip: _____

Secondary Insurance

Insurance:_____
Phone: _____ID#:_____ Group: _____
Relationship to Insured: – – (circle one) Self Spouse Child Other
Name of Insured: _____DOB: _____SS#::_____

Authorization for Release of Information and Assignment of Benefits:

I authorize the use of this signature on all insurance submissions and release of any and all medical records and/or financial information necessary to collect payment for medical services. I understand that my medical/financial information may be transmitted electronically via facsimile and/or Internet. I also authorize and assign payment of medical or government benefits directly to Infectious Diseases Doctors, P.A. and/or physician on file, for the services provided to me. I understand that I am financially responsible for the charges not covered by my insurance policy.

Signature: _____ Date: _____