Internal Medicine Associates
Washington Regional

PATIENT INFORMATION – PLEASE PRINT

SOC SEC #:_____-_____-_____ MRN#:_____

Name:_____ Home Phone:_____
Last First Middle Initial

Address:_____ Cell Phone:_____

City:_____ Date of Birth:_____-_____-_____Age:_____yrs

State:_____Zip Code:_____ Employer:_____

SEX: ☐ Male ☐ Female Work Address:_____

City:_____State:_____Zip:_____

MARITAL STATUS: ☐Married ☐Single ☐Divorced ☐Partner ☐Widowed ☐Separated

Occupation_____

PRIMARY CARE PHYSICIAN:_____ Email:_____@_____

REFERRAL

Who referred you to our clinic? (PLEASE CHECK BOX)

☐ Washington Regional Medical Center
☐ Newspaper or Magazine
☐ Recommended by friend or family member
☐ Drove by Location of Clinic
☐ Community or Company Health Fair
☐ Treated by a Physician in hospital
☐ Internet
☐ Phone Directory (Yellow pages)
☐ Referring Physician:_____
☐ Employer
☐ Insurance Plan Directory
☐ Return Patient / Not Applicable
☐ Other:_____

SPOUSE / PARENT INFORMATION

Spouse / Parent Name:_____ Cell:_____

Employer:_____ Work:_____Ext:_____

Work Address:_____ Spouse / Parent SEX: ☐ Male ☐ Female

City:_____State:_____Zip:_____ Spouse/Parent Date of Birth:_____-_____-_____

Occupation_____ Social Sec. #:_____-_____-_____

EMERGENCY CONTACT INFORMATION

Emergency contact:_____ Cell Phone:_____

Address:_____ Home Phone:_____

City:_____State:_____Zip:_____ Relationship to Patient:_____

GENERAL INFORMATION

Who is responsible for Payment?: ☐ Myself ☐ Other:_____(FILL OUT BELOW)

Responsible Party Name:_____ **Responsible Party DOB:_____-_____-_____**

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other **SS#_____-_____-_____**

Address:_____ **Phone#:_____**

Have you ever been seen as a patient at one of our Washington Regional Medical System Clinics? ☐Yes☐No

If Yes, When?:_____/_____/_____ Where?:_____

RELEASE OF INFORMATION (spouse, children, parents, etc.)

Who may we discuss your information with? For example: Medical issues / care, results, billing, etc.

Name:_____ **Relationship to Patient:_____**

Name:_____ **Relationship to Patient:_____**

Name:_____ **Relationship to Patient:_____**

Preferred Language: ☐ English ☐ Spanish ☐ Marshallese ☐ Arabic ☐ DECLINE OTHER:_____

Race: ☐ White ☐ African American ☐ Asian ☐ Native Hawaiian / Other Pacific Islander

☐ Native American Indian / Alaskan ☐ Hispanic ☐ Unknown ☐ DECLINE

Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ DECLINE

Preferred Communication Method: ☐ Print ☐ Save to Flash Drive ☐ DECLINE

Wellness Reminders: ☐ Mail ☐ Cell phone ☐ Home phone ☐ Work phone ☐ DECLINE

PREFERRED PHARMACY: _____LOCATION:_____

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent messaging. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X_____ **Date:_____/_____/_____**

Patient's Name_____**D.O.B.**_____/_____/_____

Primary Insurance

Name of Insurance Company:_____

Insurance Company Address:_____

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

Insurance Company's Phone Number_____

Member / ID #_____**Group #**_____

Subscriber / Policy holder_____**D.O.B.**_____

Please circle the patient's relationship to the subscriber: SELF SPOUSE PARENT CHILD

Effective Date:_____

Deductible amount:_____ **Please circle has your deductible been met? YES NO**

Co-Pay for PCP_____ **Co-Pay for SPECIALIST**_____

Secondary Insurance

Name of Insurance Company:_____

Insurance Company Address:_____

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

Insurance Company's Phone Number_____

Member / ID #_____**Group #**_____

Subscriber / Policy holder_____**D.O.B.**_____

Please circle the patient's relationship to the subscriber: SELF SPOUSE PARENT CHILD