

Lincoln Internal Medicine

Patient Information

Male Female

Doctor: _____

Patient's Name: _____ Home Phone: _____

Address: _____

City: _____ State/Zip: _____

Patient's Email Address: _____

Marital Status: S M W Div Sep Date of Birth: _____ Age: _____

SSN: _____

Employer: _____ Work Phone: _____

Employer's Address: _____

Spouse's Name: _____ Date of Birth: _____ SSN: _____

Spouse's Employer: _____

Employer's Address: _____ Work Phone: _____

Spouse's Home Address:
(if divorced or separated): _____ Home Phone: _____

City: _____ State/Zip: _____

Person to notify in case of emergency (note: person should not live at same residence):

Name: _____ Relationship: _____

Address: _____ Phone: _____

Insurance Information (indicate which insurance is primary [1] and which is secondary [2] in boxes below)

Name of Insurance: _____

Insurance ID # _____ Group #: _____

Subscriber: Self Spouse Other: _____

Primary Secondary

Name of Insurance: _____

Insurance ID # _____ Group #: _____

Subscriber: Self Spouse Other: _____

Primary Secondary

Please complete this section if patient is a minor.

Student: Full Time Part Time

Responsible Party's Name: _____ Date of Birth: _____

Relationship to Patient: _____

Address: _____ Home Phone: _____

City: _____ State/Zip: _____

Employer: _____ Work Phone: _____

Employer's Address: _____

Authorization for assignment of benefits and information release

I, the undersigned, authorize payment of medical benefits to Lincoln Internal Medicine for any services furnished to me by the physicians. I understand I am financially responsible for any services not covered by my insurance. I further agree to pay reasonable attorney fees and court costs in the event that legal action becomes necessary to enforce this contract. I also authorize you to release my insurance company information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date: _____ Signed: _____

** Upon receipt of the necessary information, we will bill any preferred plans in which we participate. We will also bill private insurance companies for certain procedures as a courtesy to assist you with your reimbursement. Payment is expected within thirty days. If payment is not received within this time period, any charges will become your immediate responsibility.

How did you hear about our practice? _____
