Evansville Multi-Specialty Clinic, PC

812-475-1948 • Toll Free: 1-888-401-4DOC • Fax: 812-401-1267 • www.evvclinic.com

Patient Demographic and Insurance Intake Form

Last Name: _____ **First Name:** _____ **MI:** _____

DOB: _____ **SS#:** _____ **Sex:** _____ **Marital Status:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Employer:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email: _____@_____ **Referred by:** _____

Physician Requested: _____

Are you or have you been under the care or supervision of, or received services from any state, local, or federal agency? (Example: ResCare, Visiting Nurse, SWIRCA, ARC, QRL, Compass) Circle One: Yes or No If yes, please state which agency:

_____

Insurance Information

Primary Insurance Co: _____ **ID#:** _____ **Grp #**_____

Secondary Ins Co: _____ **ID#:** _____ **Grp #:** _____

Policyholder Name: _____ **ID#:** _____ **Same as above:** _____

Policyholder DOB: _____ **Policyholder address:** _____

Policyholder SS#: _____ **Policyholder Phone Number:** _____

Emergency Contact Information

Name: _____ **Relationship to patient:** _____

Phone: _____ **Can this person receive medical information about you?** _____

Patient Authorization

Consent to the use or disclosure of my protected health information by Evansville Multi-Specialty Clinic, PC for the purpose of diagnosing or providing treatment to me, obtaining payment from any insurance company, to include, but not limited to, Medicare, Medicare supplement, Medicaid, employer, attorney or their representative to be made directly to Evansville Multi-Specialty Clinic, PC in accordance to federal, state, local, and carrier billing regulations and guidelines. In the event my account becomes more than 30 days past due and is referred to a collection agency, I agree to pay collection agency fees, reasonable attorney and/ or court cost.

I understand if I need paperwork filled out for FMLA, disability, school, or work there may be an additional fee that I will be responsible for paying prior to the paperwork being completed.

I understand that payment is expected when services are rendered unless arrangements have been (otherwise) made prior to the appointment. I understand my copay is due on every date of service. If unable to make the required copay my appointment will be rescheduled unless previous arrangements have been made.

Signature of responsible party: _____ Date: _____

If above signature does not belong to patient, please list your relationship: _____