Carlisle Family Care

1533 Commerce Avenue, Suite 1, Carlisle, PA 17015 Phone (717)240-1322 Fax (717)240-0382

PATIENT INFORMATION SHEET

IF YOU WOULD LIKE US TO CONTACT YOU TO SET UP YOUR INITIAL VISIT PLEASE CHECK THIS BOX ☐

Patient Name_____ Date:_____

Mailing Address_____City_____State_____Zip_____

Phone (home)_____ (work)_____ (cell)_____

May we leave a message at the above numbers? ☐Yes ☐No Comments: _____

SS# _____DOB _____ Age _____ Gender: ☐ Male ☐ Female

Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐

Race: American Indian ☐ Asian ☐ African American ☐ Hawaiian ☐ White ☐

Primary Language Spoken: _____

As a service to our patients, we provide a courtesy appointment reminder call that may be placed using a pre-recorded message. By providing your cell phone number, you consent to receiving such calls at this number.

What is the best phone number to be able to reach you? _____

What pharmacy do you prefer to use? _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated--If married, spouse's name:_____

Patient's Employer_____Address_____Phone_____

List doctors whom you see on a regular basis and the reason:

1.)_____ 2.)_____3.)_____

INSURANCE/BILLING INFORMATION

PRIMARY INSURANCE

Insurance Company Name_____ID#_____Group#_____Subscriber_____

Relationship to Subscriber_____Subscriber's DOB_____Subscriber's SS#_____

SECONDARY INSURANCE

Insurance Company Name_____ID#_____Group#_____Subscriber_____

Relationship to Subscriber_____Subscriber's DOB_____Subscriber's SS#_____

GUARANTOR (Person responsible for copays and for charges which are **NOT** covered by insurance)

Guarantor Name_____Guarantor SS#_____

Address (required for accurate billing) _____

AUTHORIZATION: I HEREBY AUTHORIZE THE PHYSICIANS INDICATED ABOVE TO FURNISH INFORMATION TO ANY INSURANCE CARRIERS CONCERNING MY MEDICAL CONDITION, AND I HEREBY IRREVOCABLY ASSIGN THE DOCTOR ANY PAYMENT FOR SERVICES RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

_____ _____

Patient's Signature Date

For Medicare Patients Only:

_____ _____

Name of Beneficiary Health Insurance Claim Number

"I request payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service."

_____ _____

Beneficiary Signature Date

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to _____

(Name of Medigap Insurer)

any information needed to determine these benefits payable for related services."

_____ _____

Beneficiary Signature Date