SRMC
SOUTHSIDE REGIONAL
PHYSICIANS NETWORK

Office Use Only
Place Label Here

Patient Information (must be updated yearly)

Name: (First) (Middle) (Last) Date of Birth:

Mailing Address: City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

Sex: Male Female Social Security Number: Email:
Please circle one.

Marital Status: Single Married Separated Divorced Widow/Widower Copy of ID on File: ☐
Please circle one.

Employer: Employer Phone:

Employer Address: City: State: Zip Code:

Billing Information

Responsible Party Name: (First) (Middle) (Last) Date of Birth:

Mailing Address: City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

Social Security Number: Relationship to Patient:

Primary Insurance Information Copy of Primary Insurance Card on File: ☐ (Bolded items MUST be completed)

Primary Insurance Company: Subscriber ID:

Mailing Address: City: State: Zip Code:

Policy Holder: Group Number:

Policy Holder Social Security Number: **Policy Holder Date of Birth:**

Relationship of Patient to Policy Holder: Self Spouse Child Other:
Please circle one. Please explain.

Secondary Insurance Information Copy of Secondary Insurance Card on File: ☐ (Bolded items MUST be completed)

Secondary Insurance Company: Subscriber ID:

Mailing Address: City: State: Zip Code:

Policy Holder: Group Number:

Policy Holder Social Security Number: **Policy Holder Date of Birth:**

Relationship of Patient to Policy Holder: Self Spouse Child Other:
Please circle one. Please explain.

Please complete all the information on the back of this form.

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Emergency Contact Information

Name: (First) (Middle) (Last) Relationship to Patient:

Mailing Address: City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

Referring Physician Information

Name: (First) (Middle) (Last) Phone:

Mailing Address: City: State: Zip Code:

Medicare Secondary Payor Questionnaire

Please check your answer.

Are you receiving Black Lung (BL) Benefits? ☐ Yes ☐ No

2. Are the services to be paid by a government program such as a research grant? ☐ Yes ☐ No

3. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility? ☐ Yes ☐ No

4. Was the illness/injury due to a work related accident/ condition? ☐ Yes ☐ No Date of Accident:

5. Was the illness/injury related to a non-work related accident? ☐ Yes ☐ No Date of Accident:

6. Are you entitle to Medicare based on: Age / Disability / Or ESRD (Endstage Renal Disease)?

7. Are you currently employed? ☐ Yes ☐ No Retirement Date:

Employed at:

Address:

Phone Number:

8. Is your spouse currently employed? Retirement Date:

Employed at:

Address:

Phone Number:

9. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment? ☐ Yes ☐ No

Name of Insurance Plan:

Medicare Patients Only

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration, Medigap or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature of Patient/Legal Guardian: Date: