Muenster Family Medical Clinic, LLC

Confidential Patient Information Sheet

___ New Patient
___ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

Date ___/___/____ Email Address: _____ Home Phone:_____ Work Phone:_____

Last Name_____First Name_____MI___ Cell Phone: _____

Street Address: _____ Mailing Address_____

City: _____ State _____ Zip_____

Gender: Male___ Female___ SSN: _____ - _____- _____ Birth-date ____/____/_____

Circle One: Married - Single - Partnered – Widowed Name of Partner/Spouse/Significant Other _____

Patient Employed by: _____

Business Address_____

Business Phone: _____ Occupation _____

Name of Spouse/Responsible Party (If patient is minor): _____
Last First MI

Spouse/Responsible party Employed by: _____

Business Address: _____

Business Phone: _____ Occupation _____

Responsible Party/Spouse SSN: _____-_____-_____

Do you have medical Insurance? Circle One: No Yes If yes, please fill in the following information:

Name of Primary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

Insurance Address _____

Name of Secondary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

Insurance Address _____

*This information is required by HIPPA

In case of an emergency, who should be notified? _____

Relationship _____Phone: _____

Preferred Pharmacy: _____ How did you hear about us? _____

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and even claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, hereby authorize my insurance company to pay and hereby assign directly to Muenster Family Medical Clinic, LLC all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Muenster Family Medical Clinic will be credited to my account, in accordance with the above said assignment. I also release all insurance/Medicare payments to go directly to the Muenster Family Medical Clinic, LLC.

_____ _____

(Authorized Signature of Subscriber) (Date)

Consent to Be Evaluated and Treated By a Nurse Practitioner or Physician Assistant

I understand that Muenster Family Medical Clinic, LLC employees a nurse practitioner/physician assistant to deliver care, diagnosis, and treatment of any illness or injuries that I have incurred, and that I can at any time refuse to see the nurse practitioner/physician assistant and see a physician's consultation elsewhere. I also understand that this clinic is staffed by a nurse practitioner/physician assistant and that it will be necessary for me to travel to another facility for a physician appointment.

Signed_____ Date_____