Springfield Medical Care Systems — Patient Information Form

Name:_____ Account # _____
Mailing_____ Social Security #: _____
Address:_____ Date of Birth:_____
City-State, Zip_____ Employer:_____
Home Phone:_____ Employer Address: _____
Cell Phone: _____ Work Phone:_____

RESPONSIBLE PARTY INFORMATION

Parent's Name: _____
Address: _____
If different
Social Security #:_____
Date of Birth: _____
Employer/Work Phone: _____
Self Spouse Mother Stepmother Father Stepfather Guardian

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Primary Care Physician:_____

Name: _____ Relationship: _____ Phone: _____

Please answer the following FQHC (Federally Qualified Health Center) required questions:

1. Are you a Migrant Worker? ❑ Yes ❑ No
2. Are you a US Veteran? ❑ Yes ❑ No
3. Your Ethnicity: ❑ Latino/Hispanic ❑ Other
4. Your Race: ❑ American Indian ❑ Asian ❑ African American ❑ Native Hawaiian ❑ Other Pacific Islander ❑ White ❑ More than one Race ❑ Refuse to Report
5. Your Language: ❑ English ❑ Spanish ❑ French ❑ Creole ❑ Sign Language ❑ Other

*INSURANCE INFORMATION: **WE REQUIRE A COPY OF YOUR INSURANCE CARD AND DRIVER'S LICENSE.***

- We do not participate with all insurance companies; we may be out-of-network with your plan. (i.e.: Oxford, Aetna, United Healthcare, Tufts, etc)
- You may require a referral from your insurance plan or primary care physician's office. You will need to obtain this.
- We are *not* an emergency room and cannot bill as such.

PRIMARY INSURANCE COMPANY

Insurance Name: _____ Policyholder's Address: (if different from above)
Policy/Certificate #: _____ _____
Group/Account #: _____ Suffix #_____Policyholder's suffix# _____
Policyholder: _____ Date of Birth _____ SS# _____
Policyholder's Relation to Patient: ❑ Self ❑ Spouse ❑ Mother ❑ Stepmother ❑ Father ❑ Stepfather ❑ Guardian

ADDITIONAL INSURANCE COMPANY

Insurance Name: _____ Policyholder's Address: (if different from above)
Policy/Certificate #: _____ _____
Group/Account #: _____ Suffix #_____Policyholder's suffix# _____
Policyholder: _____ Date of Birth _____ SS# _____
Policyholder's Relation to Patient: ❑ Self ❑ Spouse ❑ Mother ❑ Stepmother ❑ Father ❑ Stepfather ❑ Guardian

WORKER'S COMPENSATION INJURY? ❑ Yes ❑ No

Employer: _____ Address: _____
Contact name: _____ Date of injury: _____
& phone #: _____ Type of injury: _____

I authorize treatment necessary for the care of the above named patient. I authorize release of all medical records to referral physicians and to my insurance company for completion of insurance claim forms.
I authorize and request that insurance payments be made directly to Springfield Medical Care Systems.
Medicare Policyholders: I request that payment of authorized Medicare benefits be made on my behalf to Springfield Medical Care Systems for any services furnished to me.
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 benefits payable for related services.
I acknowledge full financial responsibility for services rendered by Springfield Medical Care Systems.
I acknowledge that if x-rays are taken, I will receive separate billings directly from Springfield Hospital/Eureka Diagnostics.
I acknowledge that Springfield Medical Care Services attaches a service fee for missed appointments,
I acknowledge that I have received a copy of the Springfield Medical Care Systems, Inc. Notice Of Health Information Privacy Practices (HIPAA)
I authorize messages to be left on my voice mail, answering machine or with a family member informing me of any appointment. ❑ Yes ❑ No

_____ _____
Signature (Authorized Person) Date