Simon-Williamson Clinic Patient Information

We keep this **confidential**, *but we need current information to communicate with you. Please inform us of any changes.*

Contact and Personal

Patient Name _____ Date of Birth: _____

Street Address *(no PO Box)* _____ Home Phone: _____

Apt./Other # _____ Cell Phone: _____

City, State ZIP _____ Work Phone: _____

Patient SSN: _____

If an Adult: *(circle)* Single Married Widowed

Spouse: _____ .....Phone: _____

Emergency Contact: _____ .....Phone: _____

If a Child: *(Circle who has legal custody if not with mother)*

Mother's Name: _____ .....Phone: _____

Address: _____ Mother's SSN: _____

_____

Father's Name: _____ .....Phone: _____

Address: _____

_____

Maternal Grandparent: _____ .....Phone: _____

Address: _____

_____

Paternal Grandparent: _____ .....Phone: _____

Other Guardian: _____ .....Phone: _____

Address: _____

_____

Employment

Patient's Employer: _____ OR Mother's Employer: _____

Spouse's Employer: _____ Father's Employer: _____

Guardian's Employer: _____

Insurance Information

Primary Insurance: _____	Secondary Insurance: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
Effective Date: _____	Effective Date: _____
Primary care Co-pay: _____	Primary care Co-pay: _____
Specialty Care Co-pay: _____	Specialty Care Co-pay: _____
Subscriber: _____	Subscriber: _____
Subscriber DOB: _____	Subscriber DOB: _____

Medicare Assignment of Benefits –Medicare Patients Only

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Simon-Williamson Clinic for any services provided 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 these benefits or the benefits payable for related
services.
I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to Simon-Williamson Clinic for any services provided to me. I authorize any holder of medical information about me to release to my MEDIGAP Insurer any information needed to determine these benefits or the benefits payable for related services.

Signature of Beneficiary _____Date _____

To Be Completed by All Patients

I understand that I am directly responsible to Simon-Williamson Clinic for all charges for medical and surgical services rendered to me or my family; regardless of insurance coverage. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees. The Clinic and its physicians and other providers are authorized to furnish any medical records requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment for my care. My signature is also my authorization of Assignment of Benefits to the Clinic.

Signature of Responsible Party _____ Date _____