PATIENT INFORMATION

Name: ____ Date of Birth: ____________________________
(First) (Last)

Sex: F M Marital Status: S M D Other:__________

Mailing Address: _____________________________________ City: _______________________ ST: ____Zip Code: ____________

Street Address:____City: _______________________ ST: ____Zip Code: ____________

Home Phone: ________________ Phone #2: __________________ E-mail: ____

INSURANCE INFORMATION

Insurance Co. : ______________________________ ID #:________________________________ Group#:_____________

Subscriber Name: ___________________________________ Date of Birth: ______________ Relationship: ______________

EMERGENCY CONTACT/NEXT OF KIN

Name: ____ Relationship: ________________

Home Phone: _______________________________________ Cell Phone: ____

PATIENT RESULTS CALLBACK AUTHORIZATION INFORMATION:

We recognize the importance of receiving a call back in a timely manner. In order for us to effectively and efficiently deliver information to you when you are unavailable, we request your permission to give information to an authorized designee. Please check the applicable boxes below and list the name of a person or persons that we may speak with if necessary.

Please list any exceptions or instructions: ____
____

I authorize Southern NH Internal Medicine to leave any message on my:

- ☐ Answering machine at home
- ☐ Answering machine at work
- ☐ Cell phone voice mail
- ☐ All

I authorize Southern NH Internal Medicine to leave a message with or speak to, those contacts listed below, regarding any information that needs to be relayed to me.

Name: ______________________________________ ______________ ______________
(Print Name) (Relationship) (phone #)

Name: ______________________________________ ______________ ______________
(Print Name) (Relationship) (phone #)

Name: ______________________________________ ______________ ______________
(Print Name) (Relationship) (phone #)

☐ I do not wish to have a contact listed to speak to regarding any information that needs to be relayed to me.

This authorization remains in effect unless otherwise revoked or revised by the patient or guardian.

All professional services rendered are charged to the patient. Patients are responsible for providing the correct insurance information at the time of service. We will complete the necessary forms to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. I hereby authorize SOUTHERN NH INTERNAL MEDICINE to furnish information to insurance carriers and I authorize insurance benefits to be made either to me or on my behalf to SOUTHERN NH INTERNAL MEDICINE.

I acknowledge that the Patient Privacy Notice (HIPAA) has been offered to me and my questions answered.

____________________________ ___________________________________ ____________________
Printed Name Patient/Guarantor Signature Date