

PATIENT INFORMATION & CONSENT

(All Spaces Must Be Completed)

PATIENT NAME _____ BIRTH DATE _____
(Last) (First) (MI)

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

YOUR EMPLOYER _____ SOCIAL SECURITY # _____

EMPLOYER'S ADDRESS _____
Street Address City State

Zip _____
MARITAL STATUS: (S) (M) (W) (D) NAME OF SPOUSE _____ BIRTH DATE _____

PREFERRED PHARMACY (Name/Address) _____

E-Mail: _____ Preferred language: (English) (Spanish) Other: _____

*RACE: (Amer.Indian) (Asian) (Black or African Amer) (White/Caucasian) (Refuse to Report/Unknown) (Native Hawaii./Pacific Islander)

*ETHNICITY: (Hispanic or Latino) (Non-Hispanic or Latino) (Refuse to Report)

PRIMARY INSURANCE CO. _____ ID # _____ GROUP # _____

INSURED'S NAME _____ RELATIONSHIP _____ BIRTH DATE _____

EMPLOYED? Y N IF YES: EMPLOYER _____

SECONDARY INSURANCE CO. _____ ID # _____ GROUP* _____

INSURED'S NAME _____ RELATIONSHIP _____ BIRTH DATE _____

EMPLOYED? Y N IF YES: EMPLOYER _____

If other than patient:

RESPONSIBLE PARTY _____ ADDRESS _____

RELATIONSHIP _____ EMPLOYER _____ SOCIAL SECURITY # _____

BIRTH DATE _____ Sex: M F _____ PHONE # _____

FAMILY PHYSICIAN _____ Address _____ Phone _____

EMERGENCY CONTACT NAME _____ phone: _____ Relationship _____

Please initial each space

- I authorize payment of medical benefits to Jeffrey M. Blake, M.D., Inc.
- I authorize release of information to my insurance carrier(s) for processing and to any collection agency/ attorney hired by provider.
- I authorize Jeffrey M. Blake, M.D., Inc. to share my medical records/medications/care with other providers as needed.
- I understand that I shall be responsible for all fees incurred for service provided to me and my dependents, regardless of insurance coverage. I further acknowledge I will be responsible for reasonable collection fees, attorney's fees and court costs incurred in any attempt by provider to collect amounts I may owe.
- I understand that in the event my account becomes overdue, and monthly payments are not made, I will be charged \$10 each month for a billing fee, unless other arrangements have been made.
- I understand that co-pays are required at the time of visit; if not paid, charges may be added to cover billing for the unpaid co-pay.
- I authorize the office of Jeffrey M. Blake, M.D., Inc. to speak and/or leave phone messages and/or fax messages regarding my medical care/appointment reminders/account at my home or cell number and with the following _____ (names) _____ (relationships). This will remain valid until revoked in writing by me.

SIGNATURE: _____ DATE: _____
INITIAL _____ DATE _____ INITIAL _____ DATE _____

*Required for federal meaningful use program.