Arthritis and Rheumatology Consultants, P.A.

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Sex: Male / Female / Other Home Phone _____ Work Phone _____

Address _____City_____State_____Zip_____

Ethnicity: Latino or Hispanic / Not Hispanic / Unknown Primary Language: _____

Employer _____ Occupation _____

Name of Spouse _____ Employer _____ Work Phone # _____

INSURANCE INFORMATION

Insurance Plan: *(please complete requested information below*)

_____
Name of Insurance Address

Group # _____ ID # _____ Copay $_____

Policy Holder Name _____ Date of Birth _____ Relationship _____

Secondary Insurance: _____
Name Address

Group # _____ ID # _____ Copay $_____

Policy Holder Name _____ Date of Birth _____ Relationship _____

ADDITIONAL INFORMATION

Emergency Contact (not living with you) _____

Relationship _____ Home Phone # _____ Work Phone # _____

Primary Physician _____ Clinic _____ Phone _____

Referring Physician _____ Clinic _____ Phone _____

By signing below I acknowledge this information is correct. I authorize my insurance company to remit payment directly to my physician for services rendered. I agree that my medical records for treatment may be released to my insurance company for claims processing. I authorize the release and disclosure of any and all of my medical records to my primary care and referring physician.

I am aware that I am responsible for any balance not paid by my insurance, and I agree to pay all statements upon receipt.

Signature _____ Date _____

Printed Name _____ Relationship to patient _____