Suburban Healthcare Associates

Account No._____
Doctor's No._____

PLEASE ANSWER ALL QUESTIONS

PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____
BIRTHDATE _____ SS# _____
HOME PHONE _____
CELL PHONE _____
EMAIL ADDRESS _____

SEX
☐ M
☐ F

Race
☐ White/Caucasian ☐ Black/African American
☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Other Race ☐ American Indian/Alaskan

Ethnic Origin
☐ Hispanic
☐ Non-Hispanic

Language _____

ADDRESS _____
CITY _____
ZIP CODE _____4 DIGIT _____
COUNTRY _____
EMPLOYER _____
WORK PHONE _____ EXT _____

ADDRESS 2 _____
STATE _____
COUNTY _____
MARITAL STATUS _____
ADDRESS _____
PRIMARY CARE DOCTOR _____

INSURANCE INFORMATION

1) INSURANCE CO _____
ADDRESS _____ ____
CITY _____ STATE _____ ZIP _____
MEDICARE/ID# _____
GROUP # _____

2) INSURANCE CO _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
MEDICARE/ID# _____
GROUP # _____

POLICY HOLDER INFO

NAME _____
RELATIONSHIP TO PATIENT _____
SS # _____
ADDRESS _____
CITY/STATE/ZIP _____
DATE OF BIRTH _____
EMPLOYER _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

POLICY HOLDER INFO

NAME _____
RELATIONSHIP TO PATIENT _____
SS # _____
ADDRESS _____
CITY/STATE/ZIP _____
DATE OF BIRTH _____
EMPLOYER _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

1) I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required). (2) We are required by applicable federal and state law to maintain the privacy of your medical information. Our Notice of Privacy Practices document informs you of our legal duties, and your rights concerning your medical information. We must follow the privacy practices described in our notice. You may request a copy of our notice at any time. (3) My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Suburban Healthcare. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will insure such payment to Suburban Healthcare.

Patient Signature _____ Date/Time _____

Responsible Party Signature _____ Date/Time _____