



ADVANCED INTERNAL MEDICINE PRACTICE

AIM for better health

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Age: _____ Date of Birth: _____ Sex: _____ SSN: _____

Home Phone: _____ Cell: _____ Work: _____

Circle Preferred Contact: Home Cell Work

Address: _____ City _____ State _____ Zip: _____

Email Address: _____

Occupation: _____

Employer Name: _____

Referred by (we would like to thank them): _____

Status (Circle one): Single Married Widow Divorced

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Preferred Pharmacy:

Name: _____

Address: _____

Insurance Information:

Insurance Name: _____

Group #: _____ Policy/ID # _____

Policy Holder Name: _____ DOB: _____ SSN: _____

Relationship to patient: Parent Significant Other Sibling Other _____

Secondary Insurance: Insurance Name: _____

Group #: _____ Policy/ID # _____

Policy Holder Name: _____ DOB: _____ SSN: _____

Relationship to patient: Parent Significant Other Sibling Other _____

I, the undersigned, certify that the above information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or the organization furnishing the services and authorize such physician or organization to submit a claim to Medicare or Insurance carrier on my behalf.

Patient /Guardian Signature: _____ Date: _____

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