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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