MICHIGAN-WISCONSIN FAMILY PRACTICE ASSOCIATES, P.C.

1711 S. Stephenson Ave. #300 Iron Mountain, MI 49801 (906)774-1633

Patient Name: ________________________________ Date of Birth: ________________

Maiden/Other Name: _________________________

Address: ___________________________________ Sex: M F Marital Status: _____________

___________________________________ SS#: ______ _____ ______

___________________________________ Spouse or Parent Name: __________________

Email: _____________________________________ May we contact you be email: YES NO

Home Phone: ( )_____-_________ Cell Phone: ( )_____-_________ Work Phone: ( )_____-________

Employer: _________________________________ Occupation: ____________________________

Preferred type of contact: (circle) Phone Mail email Ethnicity: Hispanic Non Hispanic decline

Emergency Contact: __________________________ Relationship: ________________ Phone: ( )_____-_________

Insurance Policy Holder Information

Insurance Comp.: ______________________________

Policyholder Name: ___________________________

Policyholder Date of Birth: ______________________

Policyholder SS#: _____________________________

Policy #: _________________ Group #:_____________

Relationship to Patient: _________________________

Policyholder Employer:__________________________

Secondary Insurance Policy Holder Information

Insurance Comp.: ___________________________

Policyholder Name: __________________________

Policyholder Date of Birth: _____________________

Policy holder SS#: ___________________________

Policy #: ________________Group #: ___________

Relationship to Patient: _______________________

Policyholder Employer: _______________________

I AUTHORIZE RELEASE OF ANY INFORMATION REQURIED TO PROCESS CLAIMS SUBMITTED TO MY INSURANCE CARRIER AND PERMIT PHOTOGRAPHIC OR OTHER FACSIMILE OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I HEREBY ASSIGN TO MICHIGAN-WISCONSIN FAMILY PRACTICE ASSOCIATES P.C., ANY MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I OR MY INSURED DEPENDENTS ARE ENTITLED AS A RESULT OF CLAIMS FILES WITH MY INSURANCE. I UNDERSTAND THIS ORDER DOES NOT RELIEVE ME OF MY OBLIGATION TO PAY ANY INELIGIBLE OR DISPUTED AMOUNTS OR ANY BALANCE DUE AFTER INSURANCE PAYMENTS. I UNDERSTAND THAT I HAVE THE PRIMARY DUTY AND OBLIGATION TO PAY MY DOCTOR FOR SERVICES, NOTWITHSTANDING ANY CONTRACT THAT I MAY HAVE WITH A THIRD PARTY (BE IT INSURANCE COMPANY, EMPLOYER, UNION, OR THE LIKE).

The undersigned recognizes that a condition exists requiring treatment(s) and do hereby voluntarily consent to such care, diagnostic procedure and medical treatment.

Signature____**Date** _____________________________________

Medicare Medical Authorization: Patients certification, authorization to release information, and payment release. I certify that the information given by me to applying for payment under title XVI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediate or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for me.

Signature ____ **Date** _____________________________________