

**Perimeter Medical Associates
Dr. Steven Patten
Patient Information**

PLEASE PRINT

P A T I E N T	LAST NAME		FIRST NAME		MIDDLE	NAME CALLED			
	STREET ADDRESS				APPT #	CITY	STATE	ZIP	MARITAL STATUS
	AREA CODE	HOME PHONE	AREA CODE	CELL PHONE		SOCIAL SECURITY #	SEX	DATE OF BIRTH	AGE
	EMPLOYED BY				SPOUSE'S NAME			EMPLOYED BY	
	EMPLOYERS ADDRESS				EMPLOYERS ADDRESS				
	OCCUPATION			BUS. PHONE & EX		OCCUPATION		BUS. PHONE & EX	
	NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU				RELATIONSHIP TO INSURED (ALIAS)			PHONE	

POLICY HOLDER/INSURANCE INFORMATION

COPIES OF INSURANCE CARD REQUIRED

P R I M A R Y	LAST NAME		FIRST NAME		MIDDLE	RELATIONSHIP TO PATIENT			
	STREET ADDRESS				APPT #	CITY	STATE	ZIP	
	DATE OF BIRTH		SOCIAL SECURITY #				HOME PHONE		
	EMPLOYED BY					BUS. PHONE			
	Insurance Co. Name _____								
	Mailing Address _____ City, State, Zip _____								
	(A/C) Phone # () _____ - _____ () _____ - _____								
Policy/Contract # _____									

S E C O N D A R Y	LAST NAME		FIRST NAME		MIDDLE	RELATIONSHIP TO INSURED (ALIAS)			
	STREET ADDRESS				APPT #	CITY	STATE	ZIP	
	DATE OF BIRTH		SOCIAL SECURITY #				HOME PHONE		
	EMPLOYED BY					BUS. PHONE			
	Insurance Co. Name _____								
	Mailing Address _____ City, State, Zip _____								
	(A/C) Phone # () _____ - _____ () _____ - _____								
Policy/Contract # _____									

REFERRING INFORMATION

REFERRAL SOURCE

RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Turn Over)

This is to acknowledge that I have received a copy of (Practice Name) Notice of Privacy Practices.

Date: _____ Signature: _____ Relationship to Patient: _____

**Perimeter Medical Associates
Dr. Steven Patten
Patient Information**

I REQUEST THAT PAYMENT OF AUTHORIZED benefits be made to Perimeter Medical Associates
I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

DATE _____

Signature _____

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities or any healthcare professional requiring this information.

I hereby assign and authorize payment to Perimeter Medical Associates of all medical and/or surgical benefits, including major medical policies, to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Perimeter Medical Associates by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

PERSON PROVIDING THE AUTHORIZATION _____

RELATIONSHIP TO PATIENT IF NOT PATIENT _____

Date _____

ALTERNATIVE CONTACT AUTHORIZATION

I DO DO NOT authorize you to contact or leave messages at my place of work.

Date: _____ Signature: _____

I DO DO NOT authorize you to contact me at my e-mail address.
(e-mail address if authorized _____)

Date: _____ Signature: _____

I hereby authorize you to leave messages on my home answering machine regarding appointments and to inform me that laboratory results are **available**. The laboratory **results** are NEVER left on the answering machine. You have to call the office to get them.

Date: _____ Signature: _____