

MATERNAL FETAL MEDICINE ASSOCIATES

CARNEGIE HILL IMAGING FOR WOMEN

... the leading edge in womens' health...

DEMOGRAPHIC FORM

PATIENT'S INFORMATION:

Patient's Last Name: _____ First: _____ Initial: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Age: _____ Date Of Birth: _____

Social Security: _____ Home Phone:() _____

Work Phone:() _____ Email: _____

Occupation: _____ Employer: _____

Marital Status: Single Married Divorced Widowed Other

Race: African American Hispanic Multiracial Asian Caucasian Other

EMERGENCY CONTACT:

Name: _____ Relationship To Patient: _____

Home Phone: () _____ Work Phone: () _____

REFERRAL INFO:

Referring Physician's Name: _____ Phone: () _____ Fax: () _____

Address: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ Policy #: _____ Group #: _____

Claims Address: _____ Phone: () _____

Patient's Relationship To Insured: _____ Policy Holder's Name (If Other Than Patient): _____

Subscriber's Social Security #: _____ Gender: Male Female Date Of Birth: _____

Secondary Insurance Company: _____ Policy #: _____ Group #: _____

Claims Address: _____ Phone: () _____

Patient's Relationship To Insured: _____ Policy Holder's Name (If Other Than Patient): _____

Subscriber's Social Security #: _____ Gender: Male Female Date Of Birth: _____

ASSIGNMENT AND RELEASE:

Please read the following and sign below:

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:

I hereby authorize my insurance benefits to be paid directly to Maternal Fetal Medicine Associates, PLLC or Carnegie Hill Imaging For Women, PLLC. I understand I am financially responsible for all non-covered services as well as obtaining insurance pre-authorization when necessary. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

MEDICARE PATIENTS:

I authorize any holder of medical or other information about me to the Centers of Medicare & Medicaid Services and its agents any information needed to determine benefits for this or a related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or the party who accepts assignment.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT:

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and MFM Associates Welcome Letter to new patients.

Signature: _____ Date: _____