

OFFICE USE ONLY

Date	Account #	Doctor
------	-----------	--------

PATIENT INFORMATION

First Name (Legal)	Middle Initial	Last	Previous Name	Age	Date of Birth	Sex	Mar St
Address: Street			Apt. #	Patient Employer			
City	State	Zip	Patient's Cell Phone				
Phone Number	Social Security Number		Employer Address				
This phone # will be used for appt. reminders			Employer City/State/Zip				
In Case of Emergency (Friend or Relative who does not live with you) Name and Relationship			Employer Phone				
Phone #			Spouse's Name/Parents Name (if under 18)			Spouse/Parent Employer Name	
			Spouse/Parent Employer Phone #			Student Status part-time _____ full-time _____	

BILLING INFORMATION

Responsible Party/Custodial Parent (If same as above, skip to insurance information)			Phone Number	Relationship to Patient <input type="checkbox"/> (1) Self <input type="checkbox"/> (2) Spouse <input type="checkbox"/> (3) Child <input type="checkbox"/> (9) Other			
Address - Street			Responsible Party's Employer			Phone Number	
City	State	Zip	Patient Work Phone		Patient Cell Phone		

PRIMARY INSURANCE
WORKERS COMPENSATION

Ins. Company Name & Address			Company Name & Address				
			Date of Injury				
Effective Date	Expiration Date		Contact Person & Phone Number				
Policy Holder's Name		Relationship to Patient	Policy Number	Effective Date			
Policy Number	Group Number		Workers Compensation Employer Name				
Policy Holder's SS Number	Policy Holder's Date of Birth		Workers Compensation Employer Address				
Policy Holder's Employer Name			Workers Compensation Employer City/State/Zip				
Phone Number			Workers Compensation Employer Phone				

**SECONDARY INSURANCE
(Medicare supplement or secondary insurance)**
**THIRD INSURANCE
(tertiary)**

Ins. Company Name & Address			Ins. Company Name & Address				
Policy Holder's Name		Relationship to Patient	Policy Holder's Name			Relationship to Patient	
Policy Number	Group Number		Policy Number		Group Number		
Policy Holder's SS Number	Policy Holder's Date of Birth		Policy Holder's SS Number		Policy Holder's Date of Birth		
Policy Holder's Employer Name			Policy Holder's Employer Name				
Phone Number			Phone Number				

If Medicare: Are you employed? ____ Yes ____ No Are you covered by an employer health insurance? ____ Yes ____ No

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

NAME OF REFERRING DOCTOR: _____ ADDRESS: _____

NAME OF FAMILY DOCTOR: _____ ADDRESS: _____

Medicare Secondary Payer Questionnaire: To be completed by patients who present with Medicare insurance products.

1. Do you have any group health insurance coverage based upon your current or former employment? Yes _____ No _____
2. Do you have any group health insurance coverage based upon your spouse or other family member's current employment? Yes _____ No _____
3. Are you receiving any of the following benefits?
Black Lung Yes _____ No _____
Veterans Administration Yes _____ No _____
End Stage Renal Disease Yes _____ No _____
4. Is this service related to an automobile injury or illness? Yes _____ No _____
Is this service related to a work-related injury or illness? Yes _____ No _____
Is this service related to any other third party liability injury or illness? Yes _____ No _____

If you have answered yes to any of the above questions, we will request further benefit information.

FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to pay Des Moines University it's usual charges for all services received through Des Moines University, including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Des Moines University, and direct that payment of proceeds be made directly to Des Moines University.

RECORDS RELEASE FOR CLAIMS PAYMENT

I authorize the release of medical record information or excerpts thereof to any insurance company or third party payor for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization, per HIPAA regulations.

Consent to treat I authorize the healthcare providers of DMU Clinic to administer treatment as deemed necessary for my care. As a teaching institution, students may be involved in my care. I certify that no guarantee has been made as to the results that may be obtained from the treatment.

This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

Patient's signature Date

Parent/Guardian's Signature Date