

Today's Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Maiden: \_\_\_\_\_  
Last First MI if applicable

Date of Birth (DOB): \_\_\_\_\_ Sex: **M F** Marital status: Single Married Divorced Widowed

Mailing Address: \_\_\_\_\_  
Street/P.O. Box City State Zip

SSN \_\_\_\_\_ Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Spouse name \_\_\_\_\_ Spouse DOB \_\_\_\_\_ Day phone ( \_\_\_\_\_ ) \_\_\_\_\_

Emergency contact - if different from spouse (name and phone): \_\_\_\_\_

Relative not living with patient (name and phone): \_\_\_\_\_

Who referred you to Northwest Diagnostic Clinic? \_\_\_\_\_

***If someone other than patient will be responsible for the bill, please complete this section:***

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Primary Insurance Coverage**

Name of insurance company: \_\_\_\_\_ ID #: \_\_\_\_\_

Claims mailing address: \_\_\_\_\_  
Street/P.O. Box City State Zip

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ Group/Plan #: \_\_\_\_\_ Date effective: \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Subscriber Employer/Address: \_\_\_\_\_  
Company name Street/P.O. Box City State Zip

**Secondary Insurance Coverage**

Name of insurance company: \_\_\_\_\_ ID #: \_\_\_\_\_

Claims mailing address: \_\_\_\_\_  
Street/P.O. Box City State Zip

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ Group/Plan #: \_\_\_\_\_ Date effective: \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Subscriber Employer/Address: \_\_\_\_\_  
Company name Street/P.O. Box City State Zip

**ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION FOR RELEASE OF INFORMATION**

I request that payment of authorized Medicare, Medigap or other insurance benefits be made on my behalf to Northwest Diagnostic Clinic, PA for any services furnished to me by one of the providers associated with that practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA), its agents, and/or my Medigap or other insurer any information needed to determine these benefits or the benefits payable for related services. This authorization shall continue until such time as I revoke it in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_