

**ST JOHN
MASONIC MEDICAL CENTER
PATIENT INFORMATION**

PATIENT INFORMATION:

DATE: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: _____ HOME PHONE: _____ SEX: M F DATE OF BIRTH: ___/___/___

PATIENT SSN: ____-____-____ MARTIAL STATUS: M S D

PATIENT EMPLOYER: _____ SPOUSES NAME: _____

INSURANCE INFORMATION:

INS. CO: _____ GROUP #: _____ SSN: ____-____-____ EFFECTIVE DATE: ___/___/___

WORK STATUS: FULL PART UNEMPLOYED EMPLOYER: _____

MAIN CARD HOLDER: _____ RELATIONSHIP TO PT: _____ GUAR. WORK PHONE: _____

DATE OF BIRTH: ___/___/___ SEX: M F PCP: _____ COPAY: \$ _____

IF THE PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING SECTION:

MOTHER'S NAME: _____ DATE OF BIRTH: : ___/___/___ WK PHONE: _____

FATHER'S NAME: _____ DATE OF BIRTH: : ___/___/___ WK PHONE: _____

EMERGENCY CONTACT OUTSIDE THE HOME:

NAME: _____ PHONE: _____ REL TO PT: _____

ADVANCED DIRECTIVES

FOR OFFICIAL ONLY

DO YOU HAVE AN ADVANCE DIRECTIVE? ___ YES ___ NO
WOULD YOU LIKE INFORMATION? ___ YES ___ NO

IS AN ADVANCE DIRECTIVE IN THE CHART? ___ YES ___ NO
PROVIDED PATIENT INFORMATION: _____/_____
STAFF INT. DATE

I REQUEST THAT PAYMENT OF AUTHORIZE MED ICARF/OTHER INSURANCE COMPANY BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ST JOHN MEDICAL CENTER FOR ANY SERVICES FURNISHED TO ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT/PHYSICIAN. REGULATIONS PERTAINING TO MEDICAR ASSIGNMENT OF BENEFITS APPLY. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHE INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIEROR ANY OTHER INSURANCE COMPANY ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE/OTHER INSURANCE COMPANY CLAIM. I UNDERSTAND MY SIGNATURE REQUESTS THAT P A YMEN BE MADE AND QUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM 0 DEEM 9 OF THE HCFA 1500 CLAIM FORM IS COMPLETED, _ SIGNATURE AUTHORIZES RELEASING OF THIS INFORMATION TO THE INSURER OR AGENCY SHOWN. IN MEDICARF/OTHER INSURANCE COMPANY ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT TIIIE CHARGEDETERMINATION OF THE MEDICARE/OTHER INSURANCE COMPANY AS THE FULL CHARGE AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DIDUCTIBLE, COINSURANCE, AND NON-COVERED SERVICES. COINSURANCE AND THE DEDUCTIBI ARE BASED UPON THE CHARGE DETERMINATION OF THEMEDICAREIOTHER INSURANCE COMPANY.

I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF TREATMENT OR EXAMINATION RENDERED TO ME OR MY DEPENDENT TO MY HEALTH PLAN FOR PAYMENT OF THIS CLAIM OR FOR PURPOSES DIRECTLY RELATED TO MY MEDICAL TREATMENT. I UNDERSTAND THAT, WILL BE FINANCIALLY RESPONSIBLE FOR PROCEDURES THAT ARE NOT A BENEFIT OR IS THE ATTENDING PHYSICIAN DOES NOT PARTICIPATE /N MY INSURANCE.

SIGNATURE: _____ DATE: _____