Erland Internal Medicine

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

Mailing Address (if different): _____

City: _____ State: _____ ZIP: _____ Sex: M F

Home Phone: _____ Cell Phone: _____ DOB: _____

SSN #: _____ Driver's License #: _____ State: _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino Race: American Indian/Alaska Native Asian White

Black/African American Native Hawaiian/Pacific Islander Other

Email: _____

Responsible Party: _____ Relationship: _____

Employer name: _____ Work Phone: _____

Emergency Contact #1: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact #2: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____ Group#: _____

Name of Insured: _____ Relationship: _____ DOB: _____

Address of Insured (if not self): _____

Secondary Insurance: _____ ID#: _____ Group#: _____

Name of Insured: _____ Relationship: _____ DOB: _____

Address of Insured (if not self): _____

INSURANCE ASSIGNMENT & RELEASE

I, the undersigned, have insurance coverage through _____ and assign directly to Erland Internal Medicine, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Erland Internal Medicine to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature Date