Grapevine Internal Medicine Centre
1604 Lancaster Dr. • Grapevine, TX • 76051
Phone: 817-481-8661 • FAX: 817-488-9792
www.drjohnferris.com

DATE _____

PATIENT INFORMATION

Welcome to Our Office

PATIENT'S NAME (PLEASE PRINT)	SSN	MARITAL STATUS S M W D SEP	SEX M F	BIRTH DATE	AGE

STREET ADDRESS	CITY STATE ZIP	DAYTIME PHONE	CELL HOME WORK
PATIENT OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	ALTERNATE PHONE	CELL HOME WORK
EMPLOYER'S STREET ADDRESS	CITY STATE ZIP	ALTERNATE PHONE	CELL HOME WORK
EMAIL ADDRESS	DRUG ALLERGIES IF ANY		
SPOUSE OR PARENT NAME	SSN	DATE OF BIRTH	
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	DAYTIME PHONE	CELL HOME WORK
EMPLOYER'S STREET ADDRESS	CITY STATE ZIP	ALTERNATE PHONE	CELL HOME WORK
SPOUSE STREET ADDRESS IF DIFFERENT THAN ABOVE	CITY STATE ZIP	ALTERNATE PHONE	CELL HOME WORK

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.

PERSON RESPONSIBLE FOR PAYMENT IF NOT ABOVE	RELATION TO PATIENT	DAYTIME PHONE	CELL HOME WORK
STREET ADDRESS	OCCUPATION (INDICATE IF STUDENT)	ALTERNATE PHONE	CELL HOME WORK
WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? ◯ YES ◯ NO	IF YES, WHERE WERE X-RAYS TAKEN HOSPITAL, ETC.	DATE X-RAYS TAKEN	
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIANS(S) BEFORE? INCLUDE NAME OF PHYSICIAN AND FAMILY MEMBER			
REFERRED BY	STREET ADDRESS CITY STATE ZIP	DAYTIME PHONE	CELL HOME WORK

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIERPAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH YOUR BOOKKEEPER.

YOU MAY RECEIVE A BILL FROM AN INDEPENDENT LAB IN SOME CASES. _____ **PLEASE INITIAL WHEN READ**

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder _____

I request that payment of authorized Medicare/Other insurance company benefits be made to me on my behalf to _____ for any services furnished me by that party who accepts assignment physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of CMS-1500 claim form is completed my signature authorizes releasing of the information to the insurer or the agency shown. In Medicare/Other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based on upon the charge determination of the Medicare/Other insurance company.

SIGNATURE _____ **DATE** _____