

Basic Patient Information

Patient's Social Security Number: _____

Name of Patient _____
First Middle Last

Birth Date _____ Gender **F** **M**

Street Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

Patient's Relationship to Insured?

Self Child Spouse Guardian Other _____

Please present your insurance card to the front desk receptionist when returning this form

Billing Information/Responsible Party/Guarantor for Encounter

Name of Insured _____
First Middle Last

Street Address _____

City _____ State _____ Zip _____

Birth Date _____ Guarantor's Social Security Number: _____

Gender **F** **M**

Home Phone (____) _____ Work Phone (____) _____

Guarantor's Employer _____

Insurance Coverage - Primary

Name of Insurance _____

Policy Number _____ Effective Date: (if applicable) _____

Group Name _____

Primary Care Physician _____

Name of Insured _____

First Middle Last

Birth Date _____ Retire Date (if applicable) _____

Gender **F** **M** Phone (____) _____

Name of Insured's Employer _____

Address of Insurance Holder _____

(If different than Patient Address) _____

City _____ State _____ Zip _____

Insurance Coverage - Secondary

Name of Insurance _____

Policy Number _____ Effective Date: _____

Group Name _____ Expiration Date: _____

Primary Care Physician _____

Name of Insured _____

First Middle Last

Birth Date _____ Retire Date (if applicable) _____

Gender F M Phone () _____

Name of Insured's Employer _____

Address of Insurance Holder _____

(If different from Patient Address) _____

City _____ State _____ Zip _____

Additional Patient Information

Marital Status Single Married Divorced Separated

Patient's Employment Status Full-Time Part-Time None

Spouse's Employment Status Full-Time Part-Time None

Student Status (If Applicable) Full-Time Part-Time None

Did you bring with you today the written referral form from your Referring Physician? YES NO

Referral Physician _____

Emergency Contact Information - Primary Contact

Name _____

Home Phone () _____ Work Phone () _____

Street Address _____

City _____ State _____ Zip _____

Notes/Special Directions _____

Financial Responsibility Agreement

I/We hereby authorize ISHC to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment of medical benefits to ISHC and further understand that should my account have to be referred to an attorney for collection that I am responsible for all fees and costs incurred therein.

Date _____ Patient or Guardian Signature _____

Household Assessment

Head of Household _____ Foster Child

Name of Patient

First

Middle

Last

Birth Date

SSN

Street Address

City

State

Zip

County

Proof of Income

Income

Proof of Residency

Frequency

Daily
 Monthly

Weekly
 Twice Monthly

Bi - Weekly
 Annually

Number of Foster Children

Number of Unborn Children

Household Members

Household Member 1

Name

First

Middle

Last

Birth Date

SSN

Proof of Income

Income

Frequency

Annual Income

Foster Child ?

Job Count

Household Member 2

Name

First

Middle

Last

Birth Date

SSN

Proof of Income

Income

Frequency

Annual Income

Foster Child ?

Job Count

Household Member 3

Name

First

Middle

Last

Birth Date

SSN

Proof of Income

Income

Frequency

Annual Income

Foster Child ?

Job Count

Household Member 4

Name

First

Middle

Last

Birth Date

SSN

Proof of Income

Income

Frequency

Annual Income

Foster Child ?

Job Count

Household Members Continued

Household Member 5

Name	_____	_____	_____
	First	Middle	Last
Birth Date	_____	SSN _____	Proof of Income _____
Income	_____	Frequency _____	
Annual Income	_____	Foster Child ? _____	Job Count _____

Household Member 6

Name	_____	_____	_____
	First	Middle	Last
Birth Date	_____	SSN _____	Proof of Income _____
Income	_____	Frequency _____	
Annual Income	_____	Foster Child ? _____	Job Count _____

Household Member 7

Name	_____	_____	_____
	First	Middle	Last
Birth Date	_____	SSN _____	Proof of Income _____
Income	_____	Frequency _____	
Annual Income	_____	Foster Child ? _____	Job Count _____

Household Member 8

Name	_____	_____	_____
	First	Middle	Last
Birth Date	_____	SSN _____	Proof of Income _____
Income	_____	Frequency _____	
Annual Income	_____	Foster Child ? _____	Job Count _____

Household Member 9

Name	_____	_____	_____
	First	Middle	Last
Birth Date	_____	SSN _____	Proof of Income _____
Income	_____	Frequency _____	
Annual Income	_____	Foster Child ? _____	Job Count _____

Household Member 10

Name	_____	_____	_____
	First	Middle	Last
Birth Date	_____	SSN _____	Proof of Income _____
Income	_____	Frequency _____	
Annual Income	_____	Foster Child ? _____	Job Count _____