ADVANCED PACIFIC

PATIENT INTAKE FORM

Account #: _____ Date: _____

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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

Employer: _____ Occupation: _____ Address: _____

If Minor, Name of Parents:

Parent 1: _____ Parent 2: _____

Guardian: _____

If married, spouse's name: _____ Employer: _____ Occupation: _____

Are you a student? ☐ Yes ☐ No ☐ Full-time ☐ Part-time Name of School: _____

Referring Doctor: _____ Primary Care Physician: _____

Responsible Party Information

Name: _____ Relationship to Patient: _____ Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

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

Employer: _____ Occupation: _____ Address: _____

Medical Insurance Information

Primary Insurance: _____ Group #: _____ Coverage Code: _____

Subscriber Name: _____ Date of Birth: _____ Social Security #: _____ Employer: _____

Secondary Insurance: _____ Group #: _____

Subscriber Name: _____ Date of Birth: _____ Social Security #: _____ Employer: _____

Is this a work-related injury? ☐ Yes ☐ No

Please remember that insurance is considered a method of reimbursing the doctor. Some companies pay fixed amounts for certain procedures, and others pay a percentage of the charges. It is your responsibility to pay any deductible, copay or any other balance not paid by your insurance company.

We request that charges for office visits be paid at the conclusion of the visit by either check, cash or credit card. There is a service fee of $35 on all returned checks.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. Our staff is here to assist you, but understanding your policy benefits as well as limitations remains your responsibility.

If you have an insurance plan we do not participate with, we will provide a claim to you, which you may submit to your carrier on an unassigned basis. This means your insurance plan will send the payment directly to you. Therefore, all charges for treatment are due at the time of service. We do not participate with Worker's Compensation, Motor Vehicle Accident or Third-Party liability claims.

If this account is assigned to an attorney for collection or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize the disclosure of my medical records to my insurance carrier. I hereby assign all medical and surgical benefits to which I am entitled, including Medicare, private insurance and other health plans to Dr. David Crow, Dr. Andrew Don and Dr. Stephen Sussman. The assignment shall remain in effect until revoked by me in writing. A photocopy of this original assignment is to be considered as valid as the original. I understand that I am financially responsible for charges whether or not paid by insurance. I hereby authorize Dr. David Crow, Dr. Andrew Don and Dr. Stephen Sussman to release all information necessary to secure payment. I understand that it is my responsibility to provide the office with my current and correct insurance information. If I fail to do so, I am responsible for paying in full for services rendered.

Signature of Responsible Party: _____ Date: _____

If signing as the responsible party, what is your relationship to the patient? _____