

# HARRISON HEALTHPARTNERS

## PATIENT INFORMATION FOR MEDICAL RECORDS

Full Name: \_\_\_\_\_

Preferred Name (if any): \_\_\_\_\_ Sex: M F Marital Status: M S  
D W

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

On-the-job Injury: Yes No  
If yes, date of injury: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Spouse: \_\_\_\_\_ Spouse's Birthdate: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Emergency Contact (friend or relative not living with  
you): \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone  
Number: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_ Who is your regular healthcare  
provider? \_\_\_\_\_

## MEDICAL INSURANCE INFORMATION

PLEASE PRESENT YOUR MEDICAL CARD(S) TO THE RECEPTIONIST.

THANK YOU.

**Primary Insurance:** \_\_\_\_\_ Effective Date:  
\_\_\_\_\_

Group Number: \_\_\_\_\_ ID Number: \_\_\_\_\_  
Subscriber:: \_\_\_\_\_ DOB: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Effective Date:  
\_\_\_\_\_

Group Number: \_\_\_\_\_ ID Number: \_\_\_\_\_  
Subscriber:: \_\_\_\_\_ DOB: \_\_\_\_\_

### **If you don't have Medical Insurance, will you:**

1) Be applying for Public Medical Assistance (DSHS)? \_\_\_\_\_

2) Pay by Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Care \_\_\_\_\_

If you have health insurance of any kind, we will do everything we can to help you obtain your payment from your insurance carrier. However, the basic responsibility for payment is yours. Copays and deposits for self pay patients are due at the time of service.

**ASSIGNMENT AND RELEASE:** I hereby request that payment of my insurance benefits be paid directly on my behalf to Harrison HealthPartners. I am financially responsible for any non-covered services. I understand that copays

and deposits for self pay patients are due at the time of service. I also authorize the physician to release any information required to process this claim.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICARE LIFETIME AUTHORIZATION:** I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to Harrison HealthPartners for any services furnished me by Harrison HealthPartners physicians. I authorize any holder of medical information about me to release to the CENTER FOR MEDICARE & MEDICAID SERVICES and its agents any information needed to determine these benefits of the benefits payable for related services.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_