

**FORNANCE PHYSICIAN SERVICES, INC.**  
**PATIENT INFORMATION**

Practice Name \_\_\_\_\_ Medical Record # \_\_\_\_\_

Patient Name \_\_\_\_\_  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Social Security \_\_\_\_\_ Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Employer Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Primary Health Insurance** **Effective Date** (if known) \_\_\_\_\_

Medicare No. \_\_\_\_\_  Keystone East No. \_\_\_\_\_

Blue Shield ID No. \_\_\_\_\_ Group No. \_\_\_\_\_  Health Partners No. \_\_\_\_\_

Aetna/U.S. Healthcare (HMO/PA) No. \_\_\_\_\_  Qual Med. No. \_\_\_\_\_

Other (Please give full name, address, phone number and identification numbers)  
\_\_\_\_\_  
\_\_\_\_\_

**Policy Holder Information for Primary Health Insurance:**

(If same as patient, write "same")

Name \_\_\_\_\_  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Social Security \_\_\_\_\_ Marital Status \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Employer Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer Name and Address \_\_\_\_\_

**Secondary Health Insurance** **Effective Date** (if known) \_\_\_\_\_

Insurance Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Accident Insurance Information**

(Complete this section if visit is due to an accident-related injury)

Attorney's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insurance Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Claims Adjuster Name \_\_\_\_\_ Claim Number \_\_\_\_\_

How did you learn about us? \_\_\_\_\_

**AUTHORIZATION TO RELEASE RECORDS (General Consent)**

(All patients must sign this release)

I request payment of authorized insurance benefits by one or more private or public health benefits program which I designate to pay for my care, to be made either to me or on my behalf to Fornance Physician Services, Inc. for any services furnished to me by Fornance Physician Services, Inc. physicians or other Fornance Physician Services, Inc. and/or Fornance Physician Services, Inc. health professionals. I authorize those holding records of my medical care to release copies of them or information from them to (a) my health benefits program(s) or its/their authorized representative as needed to obtain payment for the services rendered, and (b) to other healthcare providers to whom I am referred for further care.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE GIVE YOUR INSURANCE CARDS  
TO THE RECEPTIONIST FOR COPYING**

**MEDICARE AND SUPPLEMENTAL INSURANCE (ONLY)**

I request that payment of authorized Medicare benefits be made to either me or on my behalf to Fornance Physician Services, Inc. or \_\_\_\_\_ for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I request that payment of authorized Medigap benefits be made to me or on my behalf to Fornance Physician Services, Inc. or \_\_\_\_\_ for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release to \_\_\_\_\_  
(Name of Supplemental Insurance)  
any information needed to determine these benefits payable for related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_