Bowie Internal Medicine Associates

PATIENT INFORMATION SHEET

PLEASE COMPLETE FORM ENTIRELY

PATIENT DEMOGRAPHICS

PRIMARY PROVIDER AT BOWIE INTERNAL: _____

PATIENT FIRST NAME: _____ **LAST NAME:** _____

HOME ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

DATE OF BIRTH: _____(MM/DD/YYYY) **SEX:** MALE/FEMALE **ETHNICITY:** _____

HOME NUMBER: _____ **CELL NUMBER:** _____**WORK NUMBER:** _____

PREFERRED NUMBER (CIRCLE ONE) HOME/ CELL/ WORK

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ **RELATION:** _____ **TEL.** _____

□ Check here if you **DO NOT WISH** to participate in our Patient Portal.

Our patient portal is an online portal through which you can send messages, view lab results and upcoming appointments. This will help up serve you with the best care possible.

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:_____

SUBSCRIBER'S NAME: _____ **DOB:** _____ **RELATION:** _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

CLAIMS ADDRESS: _____

SECONDARY INSURANCE COMPANY NAME: _____

SUBSCRIBER'S NAME: _____ **DOB:** _____ **RELATION:** _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

CLAIMS ADDRESS: _____

PHARMACY INFORMATION

PREFERRED PHARMACY NAME/LOCATION: _____

STREET: _____ **CITY/STATE:** _____

PHARMACY TEL: _____ **MAIL ORDER PHARMACY:** _____

IF APPLICABLE (GI PATIENTS)

PRIMARY /REFERRING PHYSICIAN:_____**TEL:**_____

CARDIOLOGIST: _____ **TEL:** _____

Do you have a living will/medical advance directive: YES/NO **Do you have a DNR (Do Not Resuscitate) order: YES/NO**

I authorize my insurance benefits to be payable directly to Bowie Internal Medicine on my behalf. I understand that I am responsible for all co-insurance and non-covered charges. I understand that payment is due in full at time of service and if not I am responsible to make the appropriate financial arrangements. I consent to the release of information from my medical record as necessary for the collection of services being rendered by this establishment. **I am aware if my account is over 90 days past due, I may be discharged from the practice.**

I have received a "HIPPA omnibus rule Notice of Privacy Practices. I have reviewed the notice. A copy of this signed, dated document shall be as effective as the original. I understand that Bowie Internal Medicine reserves the right to change their privacy policy and I have the right to obtain on that request.

I also have received a copy of Bowie Internal Medicine's Financial and Cancellation/No Show Policy.

_____ _____ _____

Signature of Patient/Guardian Date