PHYSICAL MEDICINE ASSOCIATES OF NORTHERN MICHIGAN

PLEASE PRINT CLEARLY

First _____Last: _____MI: ____ Nickname: _____

SS# _____-____-_____ Birth date _ ___/_ ___/__ __ AGE: _____ Sex ☐ M ☐ F

Street Address: _____ PO Box: _____

City: _____ State: _____ Zip: _____ email_____

Phone #: ( ) _____ Home Cell Other ☐ Ok to leave message

Phone #: ( ) _____ Home Cell Other ☐ Ok to leave message

Phone #: ( ) _____ Home Cell Other ☐ Ok to leave message

Primary Care Physician: _____

Ethnic race: _____ Primary/Preferred Language: _____ Hispanic/Latino? Yes No

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Student

Circle one

EMPLOYER: _____ Work Phone #: ( ) _____

☐Full-time ☐Part-time ☐Retired ☐Disabled ☐Self Employed ☐Unemployed ☐Single

Spouse: _____ ☐ M ☐ F Birth date (required) ____/____/____ SS# _____-____-_____

Cell Phone #: ( ) _____ Work phone #: ( ) _____

DO YOU WANT TO GIVE PERMISSION TO SHARE YOUR MEDICAL INFORMATION WITH ANY OTHER PERSONS? YES NO

FIRST _____LAST: _____MI: ____ RELATIONSHIP TO YOU: _____

FIRST _____LAST: _____MI: ____ RELATIONSHIP TO YOU: _____

FIRST _____LAST: _____MI: ____ RELATIONSHIP TO YOU: _____

PRIMARY INSURANCE: _____ NAME OF SUBSCRIBER: _____

BIRTH DATE (REQUIRED): _____/_____/_____ RELATIONSHIP: _____

SECONDARY INSURANCE: _____ NAME OF SUBSCRIBER: _____

BIRTH DATE (REQUIRED): _____/_____/_____ RELATIONSHIP: _____

TERTIARY INSURANCE: _____ NAME OF SUBSCRIBER: _____

BIRTH DATE (REQUIRED): _____/_____/_____ RELATIONSHIP: _____

IS THIS A WORKER'S COMPENSATION CLAIM? ☐ NO ☐ YES IF YES, DATE OF INJURY: _____CLAIM# _____

IS THIS AN AUTO CLAIM? ☐ NO ☐ YES IF YES, DATE OF ACCIDENT: _____ CLAIM#_____

AUTO CARRIER: _____ ADDRESS: _____ CITY: _____STATE: ___ ZIP: _____

***** PLEASE CONTINUE ON REVERSE SIDE→**

I request that payment of authorized insurance benefits be made to DBMJ Rehabilitation Services, PLLC/Physical Medicine Associates of Northern Michigan on my behalf for any services furnished me, recognizing my responsibility for non-paid services. I authorize any holder of medical or other information about me to release to my insurance company or its agents any information needed to determine these benefits or benefits of related services.

I understand and agree that I am ultimately responsible for the balance of my account regardless of my insurance status. I accept responsibility for obtaining necessary referral forms, pre-certifications and/or second opinions for office visits or procedures. I will permit a copy of this authorization to be used in place of the original.

If you have included a cell phone number, you are giving our office or agent permission to call that phone.

I consent to the use or disclosure of my protected health information by Physical Medicine Associates of Northern Michigan for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Physical Medicine Associates of Northern Michigan. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. By my signature below I acknowledge receipt of the Notice of Privacy Practices.

I have read and understand the financial policy for Physical Medicine Associates.

_____ _____

SIGNATURE (required) **DATE**

IF PATIENT IS A MINOR or HAS A ***LEGAL GUARDIAN*** COMPLETE THIS SECTION**

WHO DOES THE CHILD/LEGAL DEPENDANT LIVE WITH:

☐ Mother & Father ☐ Mother ☐ Father ☐ Other (Please specify) _____

FATHER/LEGAL GUARDIAN NAME: _____

SS#_____ Father/Legal Guardian Birth date: _____/_____/_____

Father/Legal Guardian Employer: _____

Father/Legal Guardian work phone: _____Father/Legal Guardian cell: _____

Father's address: *(If different from patient)*_____

MOTHER/LEGAL GUARDIAN NAME: _____

Mother/Guardian SS#_____ Mother/Guardian Birth date:____/_____/_____

Mother/Guardian Employer: _____

Mother/Guardian work phone: _____Mother/Guardian cell: _____

Address: *(If different from patient)*_____