

**\*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

Spouse: \_\_\_\_\_  M  F Birth date (required) \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Phone #: ( ) \_\_\_\_\_ Work phone #: ( ) \_\_\_\_\_

Do you want to give permission to share your medical information with your spouse? YES NO

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

FIRST \_\_\_\_\_ LAST: \_\_\_\_\_ MI: \_\_\_\_\_ RELATIONSHIP TO YOU: \_\_\_\_\_

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**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 agree to receive text messages and/or emails regarding my account and to confirm my appointments. I may opt out of text messages and emails at any time.

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 and is available upon request.

I have read and understand the financial policy for Physical Medicine Associates of Northern Michigan. I will permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_  
**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)* \_\_\_\_\_