HEALTHSTAR PHYSICIANS, P.C.
PATIENT INFORMATION SHEET

PLEASE PRINT

Date _____ Home Phone _____

Patient _____
Last Name First Name Middle Name

Street Address _____ City _____ State ____

Zip _____ Social Security Number _____

Sex ☐M ☐F Age _____ Birthday _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐YES ☐NO IF YES, WHAT ARE THEY? _____

Patient's Employer (If child, mother's name and employer) _____ Employer _____

Business Address _____ Occupation _____ Phone _____

Spouse's Name (if child, father's name and employer) _____ Employer _____

Business Address _____

Who is responsible for this account _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? ☐NO ☐YES If yes, _____

Name of Primary Insurance _____ Insured Name _____ Birthday _____

Contract # _____ Group # _____ Insured SS # _____

Name of Secondary Insurance (if any) _____ Insured Name _____ Birthday _____

Contract # _____ Group # _____ Insured SS # _____

☐ Medicare ☐ Medicaid/TennCare Claim ID# _____

In case of emergency, who should be notified? _____ Phone _____

Have you ever been seen by a Healthstar Physician before? ☐YES ☐NO If yes, which physician? _____

How did you learn of our practice? _____ Former Physician _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to **HEALTHSTAR PHYSICIANS, P.C.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

I, the undersigned, authorize Healthstar Physicians or any agents thereof, to notify me by telephone answering machine, mail, etc. regarding appointment, lab/diagnostics, billing and collection information.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION AND RELEASE

I request the payment of authorized Medicare benefits be made either to me or on my behalf to **HEALTHSTAR PHYSICIANS, P.C.** for any services furnished me by that physician. 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 for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, of elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I, the undersigned, authorize Healthstar Physicians or any agents thereof, to notify me by telephone, answering machine, mail, etc. regarding appointment, lab/diagnostics, billing and collection information.

_____ _____
Signature of Insured/Guardian Date