# Northeast Rheumatology Initiative PLLC

NAME _____ DATE OF BIRTH _____ MARITAL STATUS _____

ADDRESS _____ AGE _____ SEX M F

CITY _____ STATE _____ ZIP _____ PHONE (H) _____ (W) _____

NEXT OF KIN _____ SOCIAL SECURITY # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ EMPLOYER _____

RELATIONSHIP _____ EMPLOYER'S ADDRESS _____

PHONE (H) _____ (W) _____ CITY _____ STATE _____ ZIP _____

WHO IS RESPONSIBLE FOR THIS BILL? ☐ PATIENT ☐ OTHER _____

NAME _____ RELATIONSHIP TO YOU _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYEP _____ SOCIAL SECURITY # _____

ARE YOU COVERED BY INSURANCE? ☐ NO ☐ YES

MEDICARE # _____

MEDICAID # _____

NO FAULT (Ask for form) _____

Other:

1. _____ ID # _____

Group # _____ Who insured: _____

Address to send claim to: _____

2. _____ ID # _____

Group # _____ Who insured: _____

Address to send claim to: _____

**COMPENSATION CASE?** Yes ____ No ____ (If yes) Date of Accident _____

Name of Compensation Insurance Carrier _____

Address _____

**LEGAL CASE?** Yes ____ No ____ (If yes) Name of Attorney _____

Address _____

**WHAT MEDICAL PROBLEM BRINGS YOU HERE?** _____

Date of Injury/Illness _____

Describe symptoms and/or how injury occurred: _____

**ASSIGNMENT AND RELEASE:** I hereby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I also authorize the physician to release any information required.

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.**

Signed _____ Date _____

**REFERRING DOCTOR:**

NAME _____

ID # _____

ADDRESS _____

Do you want your doctor to receive a copy of this report?

Yes _____ No _____