Print Form

CIC Doctor _____

Acct# _____
Date _____

Chest Infectious Diseases and Critical Care Associates, P.C.

Patient's Legal Name: _____ Male ☐ Female ☐ Age_____ Date of Birth _____

Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Address: _____ Home Phone:_____

_____ Cell Phone:_____

_____ SS #:_____

City, State, Zip

e-mail: _____

Referring Physician: _____ Clinic Name:_____

Last, First

Primary Care Physician: _____ Clinic Name:_____

Last, First

Employer: _____ Occupation:_____

Address: _____ Work Phone:_____

_____

City, State, Zip

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled

Retired from:_____

(Please enter Parent/Guardian Employment information if patient is a minor)

Student Status: ☐ Full Time ☐ Part Time

Spouse/Significant Other: _____ Work Phone:_____

Spouse's Employer: _____ Occupation:_____

Employer Address: _____

_____

City, State, Zip

Emergency Contact (Not Spouse):_____ Relationship_____

_____ Phone:_____

City, State, Zip

Language Spoken: _____

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ More than one race
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Refused to Report/Unreported
- ☐ Undefined
- ☐ White

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refused to Report/Unreported
- ☐ Undefined

Preferred Pharmacy: _____ Phone:_____

Name and Location

PRIVACY NOTICE ACKNOWLEDGEMENT OF RECEIPT

I have reviewed or received a copy of CIC's Privacy Practices Notice.

Signed: _____ Date:_____

This acknowledgement will be retained in the patient chart as a HIPAA record at CIC Associates, P.C.

INSURANCE

If patient is not the policy holder, we **must** have the policy holder's Date of Birth and Social Security #.

Primary Insurance	**Secondary Insurance**
Ins. Company Name_____	Ins. Company Name_____
Legal Name Policy Holder _____	Legal Name Policy Holder _____
Policy Holder's Social Security # _____	Policy Holder's Social Security # _____
Policy Holder's Date of Birth_____	Policy Holder's Date of Birth_____
Employer Group Name_____	Employer Group Name_____
Group ID Number _____	Group ID Number_____
Policy Holder's Ins. ID Number_____	Policy Holder's Ins. ID Number _____
Ins. Company Address _____	Ins. Company Address_____
Effective Date _____	Effective Date_____
How did you obtain this policy? _____	How did you obtain this policy? _____
(Employer, private policy, etc.)	(Employer, private policy, etc.)

PAYOR QUESTIONNAIRE

1. Do you or your spouse work for or are retired from a company that provides you with health insurance? ☐ Y ☐ N

2. Are you entitled to Medicare because of disability or End Stage Renal Disease (ESRD)? ☐ Y ☐ N
   If yes, please ✓ one: ☐ Disability ☐ Age ☐ ESRD

3. Is this illness or injury the result of an automobile accident or other injury? ☐ Y ☐ N
   If yes, please ✓ one: ☐ Auto ☐ Injured at home ☐ Other _____

4. Is this illness or injury the result of an accident or illness that occurred at work? ☐ Y ☐ N
   Date of injury:_____
   Work Comp./Employer Contact:_____
   Telephone: _____

5. Has treatment for this accident or illness been authorized by the Veteran's Administration? ☐ Y ☐ N

6. Are you entitled to any benefits under the Federal Black Lung Program? ☐ Y ☐ N

7. Are you a relative of one of our physicians? ☐ Y ☐ N

I hereby authorize the release of necessary medical information to insurance to process my claims. I hereby assign to the doctor all payments for services rendered. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made. **I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR THE AMOUNT OF PATIENT LIABILITY AND/OR SERVICES NOT COVERED BY INSURANCE. CO-INSURANCE AND CO-PAYS ARE DUE AT THE TIME OF SERVICE.**

Signed: _____ **Date:**_____