Patient Information (Internal Medicine of Milford, P.C.) Date: _____

Legal Name: _____ Gender: ☐ M ☐ F

Home Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ SS#: ____-____-_____ Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Race: _____ Preferred Language: _____ Ethnicity: _____

Home Phone# (_____)_____ Work Phone# (_____)_____Cell # (_____)_____

Where may we leave a detailed message? Home_____ Cell_____

Email Address: _____

EMPLOYER INFORMATION:

Employer's Name: _____ Occupation: _____

Employer's Address: _____

PRIMARY INSURANCE INFORMATION:

Primary Care Provider (PCP): _____

Primary Insurance Company Name: _____

Your Subscriber Identification #: _____ Policy Holder's Name: _____

Policy Holder's Birth Date: _____ Relationship: _____

Secondary Ins. Company Name: _____ Subscriber Identification #: _____

EMERGENCY CONTACT INFORMATION:

In the event of an emergency, please notify: _____
(Full Name)

Address: _____ Phone#: (____)_____ Relationship: _____
(Street & City)

I hereby authorize Internal Medicine of Milford, P.C. (IMM) to render treatment to me and/or my dependents. I request that payment of insurance benefits be made on my behalf to IMM. I authorize the release of medical information for the purposes of processing and payment claims. I understand that payment of all co-pays and deductibles are expected at the time of service and that insurance coverage is not a substitute for payment. I am responsible to pay non-covered services, including any claims resulting from my failure to notify my insurance company of my PCP selection and no-show fee for physical examinations. I understand that it is my responsibility to know my covered benefits. **We send claims as a courtesy and after 30 days, unpaid claims are due by the patient and you will be responsible for Interest, which is 12.00% APR. If your account is sent to collections, you will be responsible for attorneys' fees as well as accruing interest.**

I herby authorize release of medical information to my insurance company and other rendering providers and facilities involved with coordination of my healthcare.

I attest that all information that I have provided is accurate and true.

I have received, read or been offered a copy of the Notice of Privacy.

Signature_____