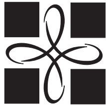

WICHITA FAMILY MEDICINE SPECIALISTS, LLC

PATIENT INSURANCE AND BILLING INFORMATION

Please Print

VERSYSS Acct. No. ___________________

Date ________________________________

Patient: (use full legal name)

Mr.
Mrs.
Miss
____
Last First Middle

____ ______________________
Maiden or other name(s) Mother's first name

__________________________ ______________________ ________
Social Security # Birthdate Age

____
Address Street Apt. # City State Zip code

(______) ____
Home phone Sex Marital status Occupation

____ (______) ________________
Employed by Employer's address Business phone

Spouse: (use full legal name)

____
Name Occupation

____ (______) ________________
Spouse's employer Employer's address Business phone

Children's name(s)

______________________________________ ______________________________________

______________________________________ ______________________________________

MEDICAL INSURANCE INFORMATION

____
Primary company Policy # Group #

____
Claims address

____
Subscriber name Subscriber date of birth

Employment status: Full time________ Part time_______ Self employed_______
Unemployed_______ Military_______ Retired_______
Student: Full time_______ Part time_______

____
Subscriber's relationship to patient Subscriber's employer

____
Secondary company Policy # Group #

____
Claims address

____
Subscriber name Subscriber date of birth

Employment status: Full time________ Part time_______ Self employed_______
Unemployed_______ Military_______ Retired_______
Student: Full time_______ Part time_______

____
Subscriber's relationship to patient Subscriber's employer

____
Medicare # Medicaid #

(continued on back)

INJURY / ACCIDENT INFORMATION

is this visit related to an injury or accident? Yes______ No_______

Automobile _______

Home _______

Worker's compensation _______

Other ____

If it is a worker's compensation injury, please complete the following:

Name of company ____

______________________________ (______) ____________________ ____________________
Company address | Company phone | Treatment authorized by

RESPONSIBLE PARTY

____
Name | Address | City | State | Zip code

______________________________ ______________________________
Social Security # | Date of birth

(______) ____
Home phone | Relationship to patient | Occupation

____
Employer

____ (_______) ______________
Employer's address | City | State | Zip code | Bus. phone

METHOD OF PAYMENT ❑ Cash ❑ Check ❑ Credit card (visa, mc)

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original , and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

____ ____________________
Signature of patient or legal guardian | Date