WICHITA FAMILY MEDICINE SPECIALISTS, LLC

PATIENT INSURANCE AND BILLING INFORMATION

Please Print

VERSYSS Acct. No. _____

Patient: (use full legal name)

Date _____

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