Peter Niemczyk, MD, FACS, LLC

PATIENT INFORMATION (2018)

PATIENT INFORMATION

Patient's Last Name: First: Middle:		❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Language: ❑ English ❑ Spanish ❑ other				
Race: ❑ White ❑ Hispanic ❑ Black or African American ❑ American Indian ❑ Asian ❑ other				
Street address:		Social Security #:		
		Cell Phone # ( )	**Home # if different** ( )	
P.O. Box: City: State: ZIP Code:				
Occupation:	Employer: Phone: ( )			
Referred by: Send report ❑ yes ❑ no		**Email:**		
Primary Care Provider (PCP): Send report ❑ yes ❑ no		❑ I do not have email	❑ I will not provide email	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: Home phone: ( )					
Please indicate PRIMARY INSURANCE:					
I.D. Number:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of SECONDARY INSURANCE (if applicable):					
I.D. Number:					
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Preferred Pharmacy Name & Phone:					

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

I acknowledge that I am responsible for all charges by Peter Niemczyk, M.D. for services provided, including any amounts not paid by my insurance carrier. I agree to forward to Peter Niemczyk, M.D. all payments I receive for services provided, immediately upon receipt. I request that payment under my medical insurance program be made to Peter Niemczyk, M.D. On any bills for services furnished to me during the effective period of this authorization. I understand that the above named provider has the right to refuse assignment (with the exception of contracted insurance plans). I authorize the above named provider to release to my insurance carrier any information needed for payment of claims. I further permit a copy of this authorization to be used in the place of the original. **Signature also acknowledges the receipt of Privacy Practices: I acknowledge that I have received a copy of this office's Notice of Privacy Practices.**

_____ _____/_____/_____

Patient/Guardian signature *Date*