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PATIENT INFORMATION FORM

PATIENT

(1) LAST NAME _____FIRST_____ D.O.B. _____/_____/_____ **Gender** Male Female

Address_____

Patient's cell #: _____ **Patient's Email:** _____

REFERRED BY _____

Ethnicity: ____ Non-Hispanic ____ Hispanic ____ Other

Race: ____ White ____ Black or African American____ Native Hawaiian ____ Asian

____American Indian or Alaska Native ____ Pacific Islander ____Other

EMERGENCY CONTACT PERSON _____

RELATIONSHIP TO PATIENT **(*** Example: mom, dad, grandparent)**_____

Address and Phone # (IF DIFFERENT THAN PATIENT'S) _____

_____

MOTHER: _____ D.O.B. _____

OR Legal guardian name: _____ D.O.B. _____

Social Security Number _____-_____-_____

Address: IF DIFFERENT THAN PATIENTS_____

***PRIMARY NUMBER FIRST**

1. Phone # _____ **(Circle One)** Mobile ● Home ● Work { MOM ___ or DAD___ }
2. Phone # _____ **(Circle One)** Mobile ● Home ● Work { MOM ___ or DAD___ }
3. Phone # _____ **(Circle One)** Mobile ● Home ● Work { MOM ___ or DAD___ }

Mom's personal E-mail: _____

FATHER: _____ D.O.B. _____

OR Legal guardian name _____ D.O.B. _____

Social Security Number _____-_____-_____

Address: IF DIFFERENT THAN PATIENT'S_____

***PRIMARY NUMBER FIRST**

1. Phone # _____ **(Circle One)** Mobile ● Home ● Work { MOM ___ or DAD___ }
2. Phone # _____ **(Circle One)** Mobile ● Home ● Work { MOM___ or DAD___ }
3. Phone # _____ **(Circle One)** Mobile ● Home ● Work {MOM___ or DAD___ }

Dad's personal E-mail _____

PHARMACY: _____

PRIMARY INSURANCE NAME _____

Subscriber / Cardholder's Name: _____ D.O.B. _____

Policy or Card Number: _____ Group #: _____

Employer's Name and Phone #: _____

SECONDARY INSURANCE NAME _____

Subscriber / Cardholder's Name: _____ D.O.B. _____

Policy or Card Number: _____ Group #: _____

Employer's Name and Phone #: _____

Patient Portal – "MyChart"

Once this form is agreed to and signed, we will give you the URL (internet address) of the web site where you can log in. We also will provide you with a user name and password in person. Use the provided internet address in your internet browser and go to the Patient Portal web site. You will then be able to log in using the user name and password provided. You should change your password to a password that only you will know.

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two important factors:

We need you to make sure we have your correct Email address and you MUST inform us if it ever changes. Do not use you work Email address, as this information might be available to your employer.

You need to keep unauthorized individuals from learning your Patient Portal password. If you think someone has learned your password, you should promptly go to the Patient Portal and change it.

*Parent/Patient Signature _____ Date _____

PRINT name _____

Authorization for Release of Medical Information and Assignment of Benefits

I authorize payments of authorized insurance benefits to Dr. Jeffrey Feldman, (JSFMDPC).

Health insurance claims are submitted by this office. In the event your insurance company denies your claim, you are responsible for the balance.

I authorize the release of any medical information needed to process my child's/children's claims.

I understand that I am financially responsible for all charges whether or not paid by insurance.

All office visit fees are due at the time of service. If applicable, insurance companies will be billed. However, Co-payments, deductibles and coinsurances are due at the time of the visit.

JSFMDPC expects full payment within 30 days of the receipt of a bill for services. In cases of financial hardships, we will accept payment plans.

In the event that this account is turned over to an agency for collection of delinquent charges, I agree to pay all costs that are associated with the collection of outstanding charges.

Signature _____ Date _____

Print Name_____ Relationship to Patient_____