

**Patient Information (Please Print)**

Today's Date: \_\_\_\_\_

|  |  |                                   |                         |                                    |                    |
|--|--|-----------------------------------|-------------------------|------------------------------------|--------------------|
| Patient's name:  |  | Social Security #:                |                         | Date of birth (mm/dd/yr)           | Age:               |
| Marital status (please circle):<br>S    M    W    D    Sep.        |  | Home phone #:<br>(    )           | Business #:<br>(    )   | Cellular/mobile phone #:<br>(    ) |                    |
| Home address:  |  |                                   | City and state:         |                                    | Zip code:          |
| Patient's employer:  |  | Occupation (indicate if student): |                         | How long employed:                 |                    |
| Employer address:  |  |                                   | City and state:         |                                    | Zip code:          |
| Spouse or parent's name:   |  | Date of birth (mm/dd/yr)          | Age:                    | Social Security #:                 |                    |
| Spouse or parent's employer:                                       |  | Occupation (indicate if student): |                         | Business Phone #:<br>(    )        |                    |
| Employer address:  |  |                                   | City and state:         |                                    | Zip code:          |
| Name of alternate person to contact if we are unable to reach you: |  |                                   | Home phone #:<br>(    ) | Work phone #:<br>(    )            |                    |
| Referred by: Name of friend, relative, MD                          |  | Location:                         |                         | Phone #:<br>(    )                 |                    |
| Primary care provider & phone #:<br>(    )                         |  |                                   | Pharmacy name:          |                                    | Phone #:<br>(    ) |
| Please provide your e-mail address:                                |  |                                   |                         |                                    |                    |

**Insurance Information:** To avoid any misunderstandings regarding your healthcare insurance, you need to: 1) Check with your insurance company to make sure we (physicians) are on your insurance plan; 2) Verify that Good Samaritan Hospital in Cincinnati is on your plan; and 3) If either of the previous answers are **NO**, you must verify that you have out of network benefits. If you are transferred or referred to our practice, it still remains your responsibility to inquire about your healthcare coverage. You will be financially responsible for all copays, deductibles and co-insurance charges.

**Insurance Authorization and Assignment:** I hereby authorize the physicians to release to my insurance company and my referring physician, any medical information necessary to process their claim for services rendered. I authorize and direct my insurance carrier to pay directly to the physicians any benefits due me under my insurance plan. I agree to pay the balance of expenses not paid under this plan.

I have read the above information:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_