MEDICAL INTERVENTIONS D/B/A URBAN HEALTH

265 West State Road 50, Clermont, FL 34711
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PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH

ADDRESS	APT NO.	CITY	STATE	ZIP

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER	WORK STATUS ☐ EMPLOYED ☐ RETIRED ☐ UNEMPLOYED ☐ STUDENT	SOCIAL SECURITY NO.	DRIVER'S LICENSE NO.

HOME PHONE	CELL PHONE	E-MAIL ADDRESS

PREFERRED METHOD OF COMMUNICATION: ☐MAIL ☐HM PHONE ☐WK PHONE ☐CELL ☐PHONE TEXT ☐EMAIL

REFERRED BY

PLACE OF EMPLOYMENT	WORK PHONE	EXT	OCCUPATION

EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	PHONE NUMBER

RACE ☐ DECLINE TO PROVIDE INFORMATION	ETHNICITY	PREFERRED LANGUAGE
☐ AFRICAN AMERICAN ☐ WHITE ☐ ASIAN	☐ HISPANIC OR LATINO	☐ENGLISH
☐ NATIVE HAWAIIAN/ PACIFIC ISLANDER	☐ NOT HISPANIC OR LATINO	☐SPANISH
☐ AMERICAN INDIAN OR ALASKA NATIVE	☐ DECLINE TO PROVIDE INFORMATION	☐ OTHER___________

PRIMARY INSURANCE		SECONDARY INSURANCE	
SUBSCRIBER ID/MEMBER ID	GROUP NO.	SUBSCRIBER ID/MEMBER ID	GROUP NO.
INSURANCE PHONE		INSURANCE PHONE	
NAME OF POLICY HOLDER		NAME OF POLICY HOLDER	
DATE OF BIRTH	SOCIAL SECURITY NO.	DATE OF BIRTH	SOCIAL SECURITY NO.
IS THIS INSURANCE PROVIDED THROUGH AN EMPLOYER? ☐ YES ☐ NO		IS THIS INSURANCE PROVIDED THROUGH AN EMPLOYER? ☐ YES ☐ NO	
PLACE OF EMPLOYMENT	EMPLOYER'S PHONE	PLACE OF EMPLOYMENT	EMPLOYER'S PHONE
RELATIONSHIP TO POLICY HOLDER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER		RELATIONSHIP TO POLICY HOLDER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY:

I hereby assign to Medical Interventions any insurance or other third party benefits available for health care services provided to me. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. If these benefits are not assigned to Medical Interventions, I agree to forward the practice all health insurance and other third party payments that I receive for services rendered to me immediately upon receipt. I recognize that I am financially responsible for all services rendered to the above named patient regardless of insurance coverage. By signing this form, I agree to assign all health insurance benefits to Medical Interventions and to be financially responsible for any co-payments, deductibles, and non-covered fees.

______________________________________ ____________________

Signature of Patient (or Responsible Party) Date