



St. Vincent Physician Network

PATIENT DEMOGRAPHIC INFORMATION FORM

PLEASE FILL OUT EVERY SPACE. IF IT DOES NOT PERTAIN TO YOU, PLEASE WRITE N/A.

How did you hear about our office? ___ St. Vincent Care Line ___ friend ___ relative ___ telephone book
___ Health fair ___ other physician ___ advertisement circle one (Radio Newspaper TV Welcome Wagon)

Patient

Patient's Name (Last, First, Middle Initial)		Birth Date	Social Security Number
Sex (Circle one) Male Female	Address (Street, Apt. #, City, State)	Zip Code	Home Telephone No.

Emergency Contact Information

Name	Relationship	Home Phone #	Work Phone #
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Mother's Information

Name		Birth Date	Social Security Number
Marital Status (Circle one) M S D W	Address (Street, Apt #, City, State)	Zip Code	
Name and Address of Employer	Home Phone #	Work Phone #	Other #

Father's Information

Name		Birth Date	Social Security Number
Marital Status (Circle one) M S D W	Address (Street, Apt #, City, State)	Zip Code	
Name and Address of Employer	Home Phone #	Work Phone #	Other #

Insurance (Primary)

Primary Insurance Company (Name and Address)		ID #	Group or Plan # (please list all characters)
Primary Insurer's Name (whose policy # is on the card)	Patient's Relationship to Insured (Circle one) Self Spouse Child Other _____	Insured's Birth Date	
Name and Address of Employer	Telephone Numbers Home- Work-	Insured's Social Security Number	

Insurance (Secondary)

Secondary Insurance Company (Name and Address)		ID #	Group or Plan # (please list all characters)
Secondary Insurer's Name (whose policy # is on the card)	Patient's Relationship to Insured (Circle one) Self Spouse Child Other _____	Insured's Birth Date	
Name and Address of Employer	Telephone Numbers Home- Work-	Insured's Social Security Number	

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fisherspediatrics.stvincent.org



FINANCIAL CONSENT FORM

By signing my name below:

I hereby guarantee payment in full within thirty (30) days of all charges established by St. Vincent for services rendered to me, unless other arrangements satisfactory to St. Vincent Health have been made. This includes any changes that a third-party payer may determine to exceed usual and customary limits.

I understand that if I am facing financial difficulty I can apply for financial assistance.

I understand and acknowledge that if any unpaid amounts owed by me are assigned to a third party for collection, I will be responsible for paying attorney fees, interest, court costs, and other costs of collection, including collection agency fees.

I authorize Medicare, Medicaid, Blue Shield, and all other commercial payers to pay St. Vincent Primary Care Network on my behalf for any services furnished to me by the provider.

This form will also give authorization for my physician to release any medical information necessary to process any insurance claims, for treatment, and for general health care operations. This includes, allowing the release of information to any specialty care provider or entity that I am referred to.

I certify that I have read this assignment of benefits, that the information given by me is correct, and that I agree to all of the provisions contained in it.

Patient Signature

Date

ANNUAL UPDATE: Please mark any corrections on the front of this form then initial and date below. This will indicate that you have reviewed and updated the Patient Information on this Form.

Initials Date

Initials Date

Initials Date

Initials Date

Initials Date

Initials Date



VERIFICATION OF INSURANCE BENEFITS

By signing my name below I am agreeing that:

The copy of the insurance card on the back of this sheet is current and has the correct insurance information.

I am still covered under this insurance policy.

The co-pay listed on the card will be paid at the time of service, per my insurance company policy.

If I sign this form and the insurance card is found later to be outdated or invalid, I understand that I am responsible for paying for the services in full and will need to file to the insurance carrier myself.

Signature & Date

Signature & Date

Signature & Date

Signature & Date

Signature & Date

Signature & Date

Signature & Date

Signature & Date

Signature & Date

Signature & Date

Signature & Date

Signature & Date

Note to Office Personnel: Make new copy of insurance card after 12th visit
ALWAYS ASK TO SEE THE INSURANCE CARD AND COMPARE TO COPY ON FILE