

UNIVERSITY MEDICAL PRACTICE ASSOCIATES — MANHATTAN MANAGEMENT SERVICES, INC.

APPOINTMENT DATE Month Day Year DR. (FOR THIS VISIT) First Name Last Name

PLEASE PRINT NEATLY

LAST NAME

FIRST NAME

HOME PHONE WORK PHONE

CELL PHONE FAX

EMAIL

PATIENT INFORMATION

STREET APT # CITY

ST. ZIP MAR. STATUS (check one): SINGLE MARRIED SEPARATED DIVORCED WIDOWED PARTNERED

DATE OF BIRTH AGE SEX SOCIAL SECURITY #

OCCUPATION EMPLOYER

EMPLOYER ADDRESS PHYSICIAN WHO REFERRED YOU

EMERGENCY CONTACT (NAME) EMERGENCY CONTACT PHONE # (THIS CANNOT BE THE SAME # AS THE PATIENT)

DO WE HAVE PERMISSION TO LEAVE MESSAGES ON YOUR VOICE MAIL OR ANSWERING MACHINE? (circle one) YES NO

PATIENT SIGNATURE DATE

By signing this consent form, I hereby authorize UMPA/MMS and its medical staff to use and disclose my personal health information, as necessary, for the purposes of obtaining medical treatment, facilitating the payment from Medicare and/or any other carrier for such treatment, and for normal business

INSURANCE COVERAGE (MAJOR MEDICAL - NOT HOSPITALIZATION)

from the front of the insurance card:

PRIMARY INS.

EMPLOYER

MEMBER#

GROUP#

POLICY HOLDER

POL. HOLDER BIRTH DATE

RELATIONSHIP TO PATIENT

from the back of the insurance card:

PHONE # FOR ELIGIBILITY/BENEFITS

CLAIMS ADDRESS

from the front of the insurance card:

SECONDARY INS.

EMPLOYER

MEMBER#

GROUP#

POLICY HOLDER

POL. HOLDER BIRTH DATE

RELATIONSHIP TO PATIENT

from the back of the insurance card:

PHONE # FOR ELIGIBILITY/BENEFITS

CLAIMS ADDRESS