GENERAL INTERNAL MEDICINE OF LANCASTER
PATIENT INFORMATION

#_____

Last Name: _____ Address: _____
First Name: _____ City: _____
Middle Name: _____ State: _____ Zip: _____ +4
Birthdate: ____/____/_____ Sex: _____M ____F SS#: _____

Phone Number: Home: _____ Work: _____ Other:_____

Marital Status: O Married O Single O Divorced O Widowed

Working: _____ Retired: _____ Student: _____

Employer: _____
Employer's Address: _____ City/State: _____
Occupation:_____ Zip: _____

Next of Kin (Person for Emergency Contact):
Last Name: _____ Address: _____
First Name: _____ City: _____
Middle Name: _____ State: _____ Zip: _____
DOB: _____ Relationship to Patient: _____
Phone Number: Home: _____ Work: _____ Other:_____

PLEASE BE SURE TO BRING THE FOLLOWING WITH YOU TO EACH VISIT:
- ALL CURRENT medical insurance cards for copying.
- If your visit is worker's compensation or auto accident related, bring billing name and address.
- In accordance with the FTC, we will need a photocopy of one of the following: Driver's license, passport or student ID. If patient is a minor, the responsible adult will need to present valid photo ID.
- Medications.
- Your completed medical questionnaire if one was given to you.

ALL PATIENTS

I GIVE PERMISSION TO Physicians' Alliance, Ltd., and its authorized employees, agents and medical providers to release my medical information to insurance carriers, health maintenance organizations, governmental agencies, and other entities or individuals charged with the fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefit otherwise payable to me to be paid directly to Physicians' Alliance, Ltd., and/or the appropriate provider. I consent to having any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I acknowledge and understand that in order to facilitate billing and related activities, my medical information will be maintained by Physicians' Alliance, Ltd., on its computer network, and that all such information will be subject to appropriate measures to protect

Signature: _____ Date: _____
(Legal guardian or parent on behalf of a minor)

FOR MEDICARE PATIENTS ONLY:

Patient Name: _____ Medicare #:_____

I request that payment of authorized Medicare benefits be made either to me, or on my behalf, to Physicians' Alliance, Ltd., for any services furnished to me by the provider of service. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

Patient Signature: _____ Date: _____

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