

**812-475-1948 • Toll Free: 1-888-401-4DOC • Fax: 812-401-1267 •** [www.evv-clinic.com](http://www.evv-clinic.com)

**Patient Demographic and Insurance Intake Form**

# Last Name: First Name: MI: DOB: SS#: Sex: Marital Status: Address: City: State: Zip Code: Employer: Home Phone: Cell Phone: Work Phone: Email: @ Referred by: Physician Requested: \_

**Are you or have you been under the care or supervision of, or received services from any state, local, or federal agency? (Example: ResCare, Visiting Nurse, SWIRCA, ARC, QRL, Compass) Circle One: Yes or No If yes, please state which agency:**

# Insurance Information

**Primary Insurance Co: ID#: Grp # Secondary Ins Co: ID#: Grp #: Policyholder Name: ID#: Same as above: Policyholder DOB: Policyholder address: Policyholder SS#: Policyholder Phone Number:**

**Emergency Contact Information**

**Name: Relationship to patient: Phone: Can this person receive medical information about you?**

**Patient Authorization**

Consent to the use or disclosure of my protected health information by Evansville Multi-Specialty Clinic, PC for the purpose of diagnosing or providing treatment to me, obtaining payment from any insurance company, to include, but not limited to, Medicare, Medicare supplement, Medicaid, employer, attorney or their representative to be made directly to Evansville Multi-Specialty Clinic, PC in accordance to federal, state, local, and carrier billing regulations and guidelines. In the event my account becomes more than 30 days past due and is referred to a collection agency, I agree to pay collection agency fees, reasonable attorney and/ or court cost.

I understand if I need paperwork filled out for FMLA, disability, school, or work there may be an additional fee that I will be responsible for paying prior to the paperwork being completed.

I understand that payment is expected when services are rendered unless arrangements have been (otherwise) made prior to the appointment. I understand my copay is due on every date of service. If unable to make the required copay my appointment will be rescheduled unless previous arrangements have been made.

# Signature of responsible party: Date:

**If above signature does not belong to patient, please list your relationship:**