TREASURE VALLEY RHEUMATOLOGY PATIENT INFORMATION SHEET

Last Name: _____ First Name: _____ M.I.: _____
Street Address: _____ Apartment #: _____
City: _____ State: _____ Zip: _____
Phone Number: (___)_____ Cell Number: (____)_____ D.O.B _____
Sex: ☐Female ☐Male SSN: _____ Marital Status: ☐Single ☐Married ☐ Other
Emergency Contact Name: _____ Emergency Contact #: _____
Email: _____ Employer: _____
Referred by: _____Primary Care Physician: _____
Pharmacy Name: _____ Pharmacy Zip: _____

Guarantor (Person Responsible for Account)

Last Name: _____ First Name: _____ M.I.: _____
Street Address: _____ Apartment #: _____
City: _____ State: _____ Zip: _____
Phone Number: (___)_____ Cell Number: (____)_____ D.O.B _____
SSN: _____ Relationship to Patient: _____
Employer: _____ Work Phone: _____ Ext: _____

INSURANCE INFORMATION

Name of Insurance Company: _____
Claims Street Address: _____
City: _____ State: _____ Zip: _____
Phone Number (for Verification): _____
Name of Policy Holder: _____ D.O.B: _____
Employer: _____ Subscriber Number: _____
Group Number: _____

INSURANCE BILLING POLICY

Our Policy is payment at time of service unless other arrangements have been made in advance. Your insurance policy is a contraction between you and your carrier. However, for your convenience we will submit your claims to your insurance company. If the insurance company forwards payment to our office, you will be reimbursed for overpayment.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Treasure Valley Rheumatology to release any information needed to my insurance carrier to determine benefits payable for related services. I hereby assign Treasure Valley Rheumatology all payments for medical services rendered to myself and / or my dependents.

_____ _____
Signature Date