Hass Family Medicine | Cape Cod

COMMITTED TO PRIMARY CARE ON THE CAPE

NEW PATIENT INFORMATION

PATIENTS NAME [PLEASE PRINT] LAST, FIRST, MI	**DOB [MM/DD/YYYY]**
STREET ADDRESS, CITY, STATE, ZIP	**SEX [MALE, FEMALE, TRANSGENDER]**
TELEPHONE NUMBERS **HOME_____CELL_____** **WORK_____ EXT_____** **MARITAL STATUS: [MARRIED SINGLE, DIVORCED, WIDOWED, PARTNER]**	**SOCIAL SECURITY #** **_____- _____ -** **_____**

EMPLOYEMENT STATUS: [CIRCLE ALL THAT APPLY] EMPLOYED FULL TIME PART TIME

SELF EMPLOYED NOT EMPLOYED RETIRED STUDENT ACTIVE MILITARY DUTY

IF EMPLOYED ENTER EMPLOYERS NAME AND ADDRESS	**EMPLOYERS PHONE NUMBER**
EMERGENCY CONTACT NAME AND NUMBER	**RELATIONSHIP**

RESPONSIBLE PARTY [THE NAME OF THE INSURANCE SUBSRIBER]

MAILING ADDRESS IF DIFFERENT THAN STREET ADDRESS [ENTER WINTER INFORMATION IF APPLICABLE]	
E-MAIL ADDRESS	**PREFERRED NUMBER TO LEAVE MESSAGE** **☐ CELL ☐ HOME**

DUE TO RECENT CHANGES IN FEDERAL REGULATIONS PERTAINING TO HEALTH INFORMATION TECHNOLOGY, WE ARE REQUIRED TO COLLECT THE FOLLOWING DATA FROM EACH OF OUR PATIENTS.

RACE:_____ ETHNICITY: [CIRCLE ONE] HISPANIC NON-HISPANIC

Hass Family Medicine | Cape Cod

COMMITTED TO PRIMARY CARE ON THE CAPE

PREFERRED LANGUAGE: _____ TRANSLATOR NEEDED: YES N0

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/other Insurance company benefits be made with to me or on my behalf to HASS FAMILY MEDICINE CAPE COD, PLLC, JOEL J HASS, MD for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or intermediaries or carries or any other insurance company any information needed for this or a related Medicare/Other Insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other Insurance company assigned cases, physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance company.

_____ _____

Patient/Patient Representative Signature **Date**

ADDITIONAL INFORMATION

Please bring all your Insurance Cards to your initial visit and submit them for scanning along with this New Patient Information form. We do collect co-insurance payment at the time of service; we accept cash, credit/debit cards and personal checks.

ADVANCED DIRECTIVES: If you have a Health Care Proxy, Living Will, DNR Order, Power of Attorney, or any other Advanced Directive, please bring them to your initial appointment for scanning to your Electronic Health Information chart.