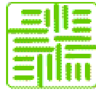

EAU CLAIRE
MEDICAL CLINIC SC

A division of Oakleaf Clinics SC

PATIENT INFORMATION

THANK YOU FOR CHOOSING OUR OFFICE! In order to serve you properly, we need the following information. Please Print. All information will be confidential.

Patient's Legal Name (Last)____(First)__________________(MI)_____

Preferred First Name: ________________________________ Maiden Name/Previous Names: __________________

SSN________________________________ Birthdate___________________________ ☐ Male ☐ Female

Address ____City__________________ State ____ Zip__________

Home Phone#________________________________ Cell Phone#____

Email Address:______________________________ Would you like information on the patient portal? Yes No

Please Check One: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race: White • Asian • Native Hawaiian • Other Pacific Islander • African American •American Indian • Alaska Native

Language: English • Spanish • Hmong • Other

Ethnicity: Not Hispanic/Latino • Hispanic/Latino

Appointment Reminders: ☐ Telephone Call ☐ Text Message *(Message & data rates may apply)* ☐ Patient Portal/Email

Patient's Employer____ Work Phone ________________

Spouse/Parent's Name__________________________Employer__________________Work Phone _______________

Spouse/Parent's Name__________________________Employer__________________Work Phone _______________

Emergency Contact Name: ____ Phone Number ______________

May we contact you or your spouse at their work number? Yes No

If patient is a student, name of school/college: ____

Who is your Primary Care Physician/Provider? ____

Whom may we thank for referring you? Dr. ___________________, Internet, Phonebook or Other:________________

RESPONSIBLE PARTY

Name of person responsible for this account _______________________________Relationship to Patient __________

Address____Home Phone _________________

Birthdate___________________Employer_________________________________ Work Phone _________________

Is this person currently a patient at our office? ☐ Yes ☐ No

INSURANCE INFORMATION *(Required, unless you are self-pay.)*

Primary Insurance _____________________________ID #_____________________Group #__________________

Policy Holder___________________________ Employer_______________________Work Phone________________

Relationship to Patient __________________________________Birthdate _____________SSN__________________

Secondary Insurance ___________________________ID # _____________________Group #_________________

Policy Holder___________________________ Employer_______________________Work Phone________________

Relationship to Patient __________________________________Birthdate _____________SSN__________________

Amounts are due in full upon receipt of our statement. Although some payment arrangements may be available, you are urged to use your own bank or credit union to finance extended payments.

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Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to understand your benefits and coverage and to obtain proper certification when needed. It is also your responsibility to pay any deductible, co-insurance, or any other balance not paid by insurance.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize the disclosure of portions of my medical record.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to OakLeaf Clinics, SC.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

***Signed:*____ *Date:* ___/___/___**

*Spouse/Parent/Guardian*_______________________________________ *Date:* ___/___/___

Patient Signature on File for Medicare Claims and any other insurance, including Medigap Insurance.

I request that payment of authorized Medicare benefits and/or Insurance benefits be made either to me or on my behalf to: OakLeaf Clinics, SC. For any services furnished to me by that provider. I authorize any hold of medical information about me to release to the CMS Administration to determine these benefits or the benefits payable for related services.

***Signed:*____*Date:* ___/___/___**

This authorization is in effect until I choose to revoke it.