DATE	DR. #	PT TYPE	PATIENT ACCNT.

INDEPENDENCE PARK MEDICAL SERVICES, INC.

PLEASE PRINT AND FILL OUT ALL SECTIONS IN FULL

PATIENT'S NAME	S.S.#	MARITAL STATUS					SEX		DATE OF BIRTH	AGE
		S	M	W	D	SEP	M	F		

MAILING ADDRESS	CITY & STATE	ZIP CODE	HOME PHONE
PATIENT'S EMPLOYER (INDICATE IF STUDENT)	EMPLOYER'S ADDRESS (IF STUDENT, NAME OF SCHOOL)		WORK/CELL PHONE
SPOUSE OR PARENT'S NAME (INDICATE RELATION)	S.S.#	EMPLOYER	WORK/CELL PHONE
NAME OF RELATIFE OR FRIEND	CITY & STATE	ZIP CODE	HOME PHONE
IN CASE OF EMERGENCY NOTIFY	PHONE	REFERRED BY:	HAVE OTHER FAMILY MEMBERS BEEN SEEN HERE? ☐ YES ☐ NO

Co-pays and deductibles are due at the time of service.
Patient is responsible for all fees regardless of insurance coverage.
All professional services rendered are charged to the patient.

PERSON RESPONSIBLE FOR PAYMENT (if other than above)	S.S.#	DATE OF BIRTH	PHONE
MALING ADDRESS	CITY & STATE		ZIP CODE
MEDICARE ID #	EFFECIVE DATE	**MEDICAID ID #**	EFFECTIVE DATE

INSURANCE COMPANY #1	POLICY HOLDER		ID #
INSURANCE COMPANY COMPLETE ADDRESS			GROUP #
DATE EFFECTIVE	ANNUAL DEDUCTABLE	% COVERED FOR OUTPATIENT SERVICE	IPMS ID CODE
POLICY HOLDER'S D.O.B.	POLICY HOLDER'S EMPLOYER		

INSURANCE COMPANY #2	POLICY HOLDER		ID #
INSURANCE COMPANY COMPLETE ADDRESS			GROUP #
DATE EFFECTIVE	ANNUAL DEDUCTABLE	% COVERED FOR OUTPATIENT SERVICE	IPMS ID CODE
POLICY HOLDER'S D.O.B.	POLICY HOLDER'S EMPLOYER		

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Independence Park Medical Services, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. An account is considered past due if the balance remains unpaid past 45 days.

SIGNATURE______________________________ DATE____________________