

**BRYANLGH HEART INSTITUTE**

**Patient Information Form**

Date:	Patient Information:	Primary Care Physician	Medical Record #:
Patient Name:			Marital Status:
Mailing Address:	City:	State:	Zip:
Home Phone:	Birthdate:	SS#:	
Employer/School:		Employer Phone:	
Parents (if patient is a minor):			

Spouse Name:	Address:	City:	State:	Zip:
SS #:	Birthdate:	Employer:	Employer Phone:	
*In Case of Emergency Contact:	Relationship:	Phone:		

Primary Insurance Co.:	Copay:	Secondary Insurance Co.:		
Address:		Address:		
City:	State:	Zip:	City:	State: Zip:
<i>Print Policyholder's Name as it appears on Insurance Card:</i>		<i>Print Policyholder's Name as it appears on Insurance Card:</i>		
Relationship to Policyholder: Self: ___ Wife: ___ Husband: ___ Child: ___ Other: ___		Relationship to Policyholder: Self: ___ Wife: ___ Husband: ___ Child: ___ Other: ___		
Group Number/Group Name:	ID#:	Group Number/Group Name:	ID#:	

**If you have Medicare, please complete the following questions:**

- Are you a Veteran? YES \_\_\_ NO \_\_\_ If yes, did the VA refer you here for treatment? YES \_\_\_ NO \_\_\_
- Are you receiving Black Lung Benefits? YES \_\_\_ NO \_\_\_
- Do you have End Stage Renal Disease (kidney disease)? YES \_\_\_ NO \_\_\_
- Is this medical condition related to an accident of any kind? YES \_\_\_ NO \_\_\_  
If YES was it:  
Work Related \_\_\_ (please complete worker's comp form)  
Auto \_\_\_ (please complete MVA form)  
Injured at home \_\_\_  
Other \_\_\_\_\_
- Do you have group health coverage based on your own or a family member's current employment? YES \_\_\_ NO \_\_\_
- Are you a current resident in a Skilled Nursing Facility? YES \_\_\_ NO \_\_\_  
If YES, Name of Facility: \_\_\_\_\_ Address of Facility: \_\_\_\_\_

If any answer to the above questions 1-4 is yes, the corresponding section of the Other Insurance form must be filled out completely.

I hereby authorize BryanLGH Heart Institute as the holder of medical or other information, to release to the Social Security Administration and Centers for Medicare and Medicaid Services or it's intermediaries or carrier or any other commercial insurance company, any information needed for this or future related claim(s). I further give lifetime authorization for payment of insurance benefits to be made directly to BryanLGH Heart Institute and authorize claims to be submitted on my behalf for any bills or services furnished. My insurance coverage is a contract between me and my insurance company. I am responsible for 1) charges for services not considered covered benefits, 2) unpaid balances, 3) obtaining any referrals, and 4) authorizations required by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I authorize BryanLGH Heart Institute to administer medical treatment. I agree that a photocopy of this agreement shall be as valid as the original. If we refer your past due account to an outside collection agency or credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

I have received notice of this organization's privacy practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

To be completed if any of the first four questions on the MSP form are answered yes.

Date: _____		Medical Record #: _____	
BHI Physician: _____		Referring Physician: _____	
Patient Name: _____		Age: _____	Sex: _____ Marital Status: _____
Mailing Address: _____		City: _____	State: _____ Zip: _____
Home Phone: _____	Work Phone: _____	Birthdate: _____	SS#: _____

**Veterans Administration (VA) Authorization Information**

Does the patient authorize you to bill the VA? Yes \_\_\_\_\_ No \_\_\_\_\_

**Black Lung Insurance Information**

Are the services you are receiving today related to lung disease? Yes \_\_\_\_\_ No \_\_\_\_\_

If the answer is 'Yes', submit claims to:

Federal Black Lung Program  
 P.O. Box 828  
 Lanham-Seabrook, MD 20703-0828

**Worker's Compensation Insurance Information**

Date of Accident: _____	Has the case been Settled? Yes-Date _____ No _____
Employer Name: _____	Employer Identification Number: _____
Employer Address: _____	City/State/Zip: _____
Name of Insurance Company: _____	Name of Person or Company Insured: _____
Insurance Company Claim/Policy Number: _____	Worker's Compensation Claim Number: _____
Name/address of Worker's Compensation Agency where claim was filed: _____	
Name/phone number of Patient's Legal Representative in this case (if any): _____	

**Automobile, No-Fault or Liability Insurance Information**

Date of Accident: \_\_\_\_\_ If other than auto, describe accident: \_\_\_\_\_

Name of Business or Property Owner: \_\_\_\_\_ Address: \_\_\_\_\_ Telephone#: \_\_\_\_\_

Type of Insurance: Premises Medical \_\_\_\_\_ Liability \_\_\_\_\_

Are you or a family member going to file a liability Claim in connection with this injury? Yes \_\_\_\_\_ No \_\_\_\_\_

**Complete Section below if an Auto, Premises Medical or Liability Claim will be filed.**

Name of Policyholder: \_\_\_\_\_

Policy Number/Claim Identification Number: \_\_\_\_\_ Address of Policyholder: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Address of Insurance Company: \_\_\_\_\_

Name of Patient's Legal Representative for this case (if any): \_\_\_\_\_

Phone number of Legal Representative: \_\_\_\_\_

**Group Health Plan Information (Patient's Own Coverage)**

Insurance Company: _____	Employer Identification Number: _____
Policy Number: _____	Claim Number: _____
Insurance Plan Name: _____	Plan Identification Number: _____
Employed: Full-Time _____ Part-Time _____	Employer Name: _____
Employer Address: _____	City/State/Zip: _____
Does employer have more than 20 employees? Yes _____ No _____ More than 100? Yes _____ No _____	

**Group Health Plan Information (coverage through Spouse or Other Family Member's Insurance)**

Insured's Name: _____	Relationship to Patient: _____
Insurance Company: _____	Plan Identification Number: _____
Employer Name: _____	Full-Time _____ Part-Time _____
Employer Address: _____	City/State/Zip: _____
Does employer have more than 20 employees? Yes _____ No _____ More than 100? Yes _____ No _____	