

# Union Internal Medicine Specialties, Ltd.

Internal Medicine/Pulmonary Disease/Critical Care/Sleep Medicine

515 Union Avenue, Suite 187 • Dover, Ohio 44622

Phone: (330) 343-4411 • Fax: (330) 364-1114

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Michael M. McCombs, D.O. • William V. Swoger, D.O. F.C.C.P., F.A.A.S.M., F.A.C.O.I. • Michele D. Fleak, M.D.  
Stacey F. Miller, MSN, FNP-BC • Mathew C. Armstrong, MSN, FNP-BC

Date: \_\_\_\_\_

## NEW PATIENT INFORMATION

Patient Name (Last, First, Initial): \_\_\_\_\_

Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Patient Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Business Telephone \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## INSURANCE INFORMATION

Insured's Name (Last, First, Initial) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Does your Insurance Company require pre-authorization on procedures over \$200? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Birthdate of Spouse \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Medical Card (Case Number) \_\_\_\_\_

## INSURANCE AUTHORIZATION AND ASSIGNMENT

In case of an emergency, the nearest relative's name (other than spouse) \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

I understand and agree that, (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information on this form and have completed all answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any change in my health status of the above information.

I authorize the release of any medical information necessary to process this claim. I further authorize payment of medical benefits to Union Internal Medicine Specialties, Ltd., for all services rendered.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR MEDICARE PATIENTS ONLY**  
**Statement to Permit Payment of Medicare Benefits to Provider, Physician and Patient**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the medical insurance program be made either to me or to \_\_\_\_\_  
on any bills for services rendered me by Union Internal Medicine Specialties, Ltd.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Health Insurance Claim Number