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

Michael M. McCombs, D.O. • William V. Swoger, D.O., F.C.C.P.
Keith C. VanEpps, M.D. • Michele D. Fleak, M.D. • Douglas Fronzaglia II, D.O.

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