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Seth Criner, D.O., M.S., Inc.

PATIENT INFORMATION

NAME_____
ADDRESS_____
CITY_____ST_____ZIP_____
DATE OF BIRTH_____AGE_____
SOCIAL SECURITY # _____
HOME PHONE _____
CELL PHONE _____
EMAIL ADDRESS _____
EMPLOYER _____
ADDRESS _____
CITY _____ST_____ZIP_____
WORK PHONE_____
OCCUPATION_____
SEX _____ RACE _____ LANGUAGE _____
ETHNICITY_____MARITAL STATUS_____

SPOUSE/PARENT INFORMATION

NAME _____
ADDRESS _____
CITY _____ST_____ZIP_____
DATE OF BIRTH _____
SOCIAL SECURITY #_____
HOME PHONE _____
CELL PHONE _____
EMAIL ADDRESS _____
EMPLOYER _____
ADDRESS _____
CITY _____ST_____ZIP_____
WORK PHONE _____
OCCUPATION _____

EMERGENCY CONTACT_____ PHONE #_____
REFERRED BY _____ PRIMARY CARE PHYSICIAN _____
PHONE NUMBER PREFERRED FOR APPOINTMENT REMINDERS _____

PRIMARY INSURANCE

PLAN NAME _____
BILLING ADDRESS _____
CITY _____ST _____ZIP_____
GROUP # _____
SUBSCRIBER # _____
EFFECTIVE DATE _____
INSURED NAME _____
RELATIONSHP TO PATIENT_____
PHONE #_____

SECONDARY INSURANCE

PLAN NAME _____
BILLING ADDRESS _____
CITY _____ST_____ZIP_____
GROUP # _____
SUBSCRIBER # _____
EFFECTIVE DATE _____
INSURED NAME _____
RELATIONSHP TO PATIENT _____
PHONE # _____

DOES YOUR INSURANCE REQUIRE AN AUTHORIZATION PRIOR TO SEEING A SPECIALIST? Yes___ No___
DO YOU HAVE A COPAYMENT? Yes ___ No ___ AMOUNT $_____

WORKERS' COMPENSATION INSURANCE INFORMAITON

INSURANCE NAME _____
ADDRESS _____
CITY _____ST _____ ZIP _____
PHONE _____
ADJUSTER _____
PHONE _____
FAX _____
NCM _____
PHONE _____
FAX _____

EMPLOYER DURING INJURY _____
ADDRESS _____
CITY _____ST _____ZIP_____
PHONE _____
DOI _____ CL# _____BODY PART _____
DOI _____ CL# _____BODY PART _____
DOI _____ CL# _____BODY PART_____

INT NEEDED? Y____ N____ PHONE _____
NAME OF AGENCY _____

For visual identification we photograph our patients, please **CHECK** if you **DO NOT** want this done: ☐
I hereby authorize directly to, Seth Criner, D.O., M.S., Inc. All surgical and medical benefits otherwise pay-able to me for services performed. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Signature _____ Relationship _____ Date _____

*Note: please notify us if any of the above information changes during the course of your treatment.

I authorize Dr. Criner to examine me today for my medical condition and to prescribe medications for my treatment. In the event my physician refers me to another provider; I authorize release of my records to that provider for the purpose of coordination of care.

I authorize release to my insurance carrier, employer (in the case of a work-released injury), and/or attorney any information necessary to process and pay the charges incurred by me from this physician. I further authorize my physician to release records relating to my treatment to my referring and/or primary care physician. I acknowledge that I am responsible for any co-payments or balances due that remain unpaid by my insurance carrier.

I authorize my insurance carrier to make direct payment to the above named physician for all services performed.

_____ _____
Signature of patient or guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Seth Criner, D.O., M.S., Inc. Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Seth Criner, D.O., M.S., Inc. may disclose and use my protected health information.

Patient name _____

Signature _____ date _____

If signed by the patient's person representative, indicate:

Name of signer _____

Relationship to patient _____

If acknowledgment not signed, indicate reason no signed and efforts made to have acknowledgement signed:

_____

_____