

PLEASE COMPLETE ENTIRE SHEET

Have you been a patient at any of the McGreevy Clinic Avera locations? Yes _____ No _____

Please Print

Patient: _____ Birthdate: _____
Last First Middle Initial Maiden Name

Patient Social Security Number: _____ Telephone: _____

Sex: M F Marital Status: S SEP WID DIV M Spouse's Name: _____

Home Address: _____
Street Apt. # City State Zip

Cell Phone: _____ Employer: _____ Work Telephone: _____

Person's name with whom child is living: _____ Relationship: _____

Nearest adult relative not living in same household: _____

Address: _____ Telephone: _____
Street City State Zip

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: (If any charges are related to Worker's Compensation please notify the reception area. We must have billing information to file Worker's Compensation.)

Name: _____ Sex: M F
Last First Middle

Relationship to Patient: _____ Social Security Number: _____

Address: _____ Telephone: _____
Street City State Zip

Occupation: _____ Employer: _____ Work Telephone: _____

INSURANCE INFORMATION: We file primary and secondary insurances if we receive copies of both insurance cards. This area must be completed for primary insurance. **(Complete secondary information on back of sheet.)**

Primary Insurance Company: _____ Effective Date: _____

Address of Insurance Company: _____

Policyholder: _____ Policyholder's date of birth: _____ Type of Coverage: Family or Single

ID #: _____ Group #: _____ Employer: _____

Co-payment: \$ _____

Has any member of your immediate family been a patient at McGreevy Clinic? Yes _____ No _____

How did you learn of our clinic? _____ Request for Dr. _____

I hereby assign all payments for medical/surgical services rendered by McGreevy Clinic Avera physicians including Medicare, private insurance, and other health coverage to McGreevy Clinic Avera. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, including any amount not covered by my insurance company.

I authorize McGreevy Clinic Avera to furnish medical information necessary to process insurance claims for me or my covered dependents.

SIGNATURE (Patient, Parent or Guardian if child is under 18 years old)

DATE

Person taking sheet (initials)



INSURANCE INFORMATION: We file primary and secondary insurances if we receive copies of both insurance cards. This area must be completed for secondary insurance.

Secondary Insurance Company: _____ Effective Date: _____

Address of Insurance Company: _____

Policyholder: _____ Policyholder's date of birth: _____ Type of Coverage: Family or Single

ID #: _____ Group #: _____ Employer: _____

Co-payment: \$ _____
