

APPLICATION FOR MEDICAL CARE

Jeffrey Crowell, M.D.

P.O. Box 665 • Effingham, IL 62401

(PLEASE PRINT CLEARLY)

Have you been seen previously by: Dr. Brummer Dr. Bingham Dr. Heischmidt Dr. Crowell

Application for family individual Date of Application _____

Guarantor's Full Name: _____ Age: _____ DOB: _____

Previous/Maiden Name: _____

Address: _____ City: _____ St.: _____ Zip: _____

Home Phone: _____ Married Single Divorced Separated Widowed

Social Security No.: _____ Driver's License No.: _____

Guarantor's Employer: _____ Phone No.: _____ Ext.: _____

Address: _____ City: _____ St.: _____ Zip: _____

Occupation: _____

Spouse: _____ DOB: _____ Social Security No.: _____

Spouse's Employer: _____ Phone No.: _____ Ext.: _____

Address: _____ City: _____ St.: _____ Zip: _____

Occupation: _____

Present Physician: _____ Referred By: _____

In case of emergency, contact (Other than spouse): _____

Address: _____ City: _____ St.: _____ Zip: _____

Relationship: _____ Phone No.: _____ Ext.: _____

Children's Full Name: _____ DOB: _____ Soc. Sec. No.: _____ Sex _____

_____ DOB: _____ Soc. Sec. No.: _____ Sex _____

_____ DOB: _____ Soc. Sec. No.: _____ Sex _____

_____ DOB: _____ Soc. Sec. No.: _____ Sex _____

_____ DOB: _____ Soc. Sec. No.: _____ Sex _____

INSURANCE INFORMATION:

Primary Coverage, Name of Carrier & Address

Secondary Coverage, Name of Carrier & Address

Group No.: _____

Group No.: _____

Identification No.: _____

Identification No.: _____

Subscriber Name: _____

Subscriber Name: _____

Subscriber's Birthdate: _____

Subscriber's Birthdate: _____

Effective Date: _____

Effective Date _____

Are you covered by Medicaid? Yes No

Please give secretary a current copy of Medicaid form.

Medicaid No.: _____

We ask all patients to show their insurance membership card so that we may copy them. Medicaid Card must be presented at each visit or payment is due the day of service. We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections for insurance companies and will credit and such collection to the patients account.

I give my consent to **Family Care Associates of Effingham, S.C.** to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of my family members. I have been informed and understand that I am personally responsible for the full payment of my account. In the event my account is past due more than 60 days, a finance charge will be assessed. If I have not made arrangements for payments after 90 days, I will be responsible for all fees incurred for collection and/or attorney fees.

We require payment, and/or co-payment, the day of service for all office visits.

Signature: _____ Date: _____

Have you applied here before? Yes No