APPLICATION FOR MEDICAL CARE

Thomas Heischmidt 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: _____ (LAST / FIRST / MIDDLE) Age: _____ DOB: _____

Previous/Maiden Name: _____

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

Home Phone: _____ Cell Phone: _____ ☐ Married ☐ Single ☐ Divorce ☐ Separated ☐ Widowed

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

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

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

Occupation: _____

Email Address: _____

☐ Spouse: _____ (Last / First / Middle) 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: _____

Email Address: _____

☐ 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

Address

Group No.: _____

Identification No.: _____

Subscriber Name: _____

Subscriber's Birthdate: _____

Effective Date: _____

Are you covered by Medicaid? ☐ Yes ☐ No

Medicaid No.:

Secondary Coverage, Name of Carrier &

Address

Group No.: _____

Identification No.: _____

Subscriber Name: _____

Subscriber's Birthdate: _____

Effective Date: _____

Please give secretary a current copy of Medicaid form.

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.

I hereby authorize **Family Care Associates of Effingham, S.C**. to file claims and/or make inquiries in my behalf, accept assignment, and provide information regarding my care and treatment to my insurance carrier. 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 assesed. If I have not made arrangements for payments after 120 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