

# APPLICATION FOR MEDICAL CARE

Colleen Bingham, 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: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  Married  Single  Divorced  Separated  Widowed

Social Security No.: \_\_\_\_\_ Driver's License No.: \_\_\_\_\_

Guarantor's Employer: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Ext.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

Email Address: \_\_\_\_\_

Spouse: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Spouse's <sup>Last</sup>Employer <sup>First</sup> <sup>Middle</sup> \_\_\_\_\_ 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

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. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections for insurance companies and will credit any such collection to the patients account.

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 120 days, and I have not made arrangements for payments, 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