Allison Win, M.D. LLC.

****MEDICARE PATIENTS PLEASE PRINT YOUR NAME AS IT APPEARS ON YOUR MEDICARE CARD****

First Name: **Middle:** **Last:** **Suffix:** **Male** ☐ **Female** ☐ **Date of Birth:**

Marital Status: (please circle)
Single/Married/Separated/
Divorced/Widowed

Race:
☐ **Asian**
☐ **Black/African American**
☐ **White**
☐ **Am Indian or Alaskan Native**
☐ **Native Hawaiian /Pacific Islander**

Ethnicity:
☐**Hispanic or Latino**
☐**Non Hispanic or Latino**

Language(s) Spoken:
☐ **English**
☐ **Spanish**
Other: _____

Social Security #:

Address: **City:** **State:** **Zip Code:**

Home Phone: **Work Phone:** **Cell Phone:** **Email Address:** ***Required***

May we request Pharmacy Benefits on your behalf and send Electronic Prescriptions? **Yes** ☐ **No**☐

Pharmacy Name: **Address:** **City, State, Zip Code:** **Phone #:**

Primary Insurance Name: **Primary Insurance ID#:** **Group #:** **Copayment:**

Responsible Party: (First Name, Last) **Male** ☐ **Female** ☐ **Date of Birth:** **Social Security #:**

Secondary Insurance: **Secondary Insurance ID#:** **Group #:**

Responsible Party: (First Name, Last) **Male** ☐ **Female** ☐ **Date of Birth:** **Social Security #:**

Referring Physician: **Address and Phone #:**

Other Physicians You May Have: **Relationship:**

Emergency Contact Name and Phone #'s): **Relationship:**

Employment (Name, Address and Phone #)

Patient Consent:

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I have been given access to the NOTICE OF PRIVACY PRACTICES for ALLISON WIN MD LLC and understand its contents.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Provider Name Here for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

X _____

Patient's Signature **Date**