

OSTEOPATHIC HEALTHCARE OF MAINE

Patient Name _____ DOB _____ Sex _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____

Relationship Status: S P M D W Who referred you to OHM? _____

Parent's Name (if child) _____ DOB _____

***Is this a work-related injury? Y N	Has your employer been informed? Y N
Date of Injury _____ Claim # _____	Adjuster _____ Phone _____
Nurse Case Manager _____ Phone _____	Attorney _____ Phone _____
***Is this an injury the result of an accident? Y N	Date of Accident _____ Claim # _____
Med Pay Info _____	

Primary Care Physician _____ Phone _____

INSURANCE:

Primary Insurance _____

Policy ID Number _____ Group Number _____

Is a referral required by your insurance? _____ Number of visits authorized _____

Do you have a Deductible? _____

Secondary Insurance _____

Policy ID Number _____ Group Number _____

Do you have Maine Care? _____ If yes, are you a QMB participant? _____

ASSIGNMENT OF BENEFITS:

Co-payments are due at the time of service. I authorize payment of medical benefits from my insurance provider to **Osteopathic Healthcare of Maine** for services provided by Dr. Hankinson, Dr. Wu, Dr. Gilson, Dr. Hilton, & Dr. Jeffrey Greenfield and do understand that I will be responsible for any balance, including a balance for any non-covered services, after my claims have been submitted and processed by insurance.

SIGNATURE

DATE

PATIENT NOTIFICATION

Patients who do not give a 24-hour notice or do not arrive for a scheduled appointment may be charged a missed appointment fee.

Patient Name: _____

Circle One

Cell: _____

Okay to leave message? Yes / No

Okay to send Text Message? Yes / No

Home: _____

Okay to leave message? Yes / No

Work: _____

Okay to leave message? Yes / No

Emergency Contact: _____ Contact Telephone: _____

Relationship to Patient: _____

*****NEED TO COMPLETE THIS SECTION*****

Select One:

- I do **not** want any information about my healthcare communicated to family members/caregivers.
- I give Osteopathic Healthcare of Maine permission to verbally communicate to family members/caregivers listed below.

Name: _____

Name: _____

Please check the box next to the specific information that may be **verbally** communicated to the individual(s) listed above:

- Prescription Request
- Referral Request
- Billing questions
- Request/Confirm/Cancel Appointments
- Other (specify): _____

This authorization expires 12 months from the date hereof. I have the right to revoke this authorization in writing at any time. Revocation will not cover information/material released prior to that date but will prevent further release of information.

If you would like to grant permission to Osteopathic Healthcare of Maine to discuss AIDS/HIV, Alcohol and/or Drug Abuse, or Mental Health with anyone but yourself, please request a *Medical Release Form*.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____