

GORDON L GRADO, MD, INC
PATIENT INFORMATION SHEET
(Please Print)

Date: _____ Glendale * Scottsdale * Minneapolis

Patient Name: _____ SS# _____
Last First Middle

Mailing Address: _____ Phone _____
PO Box/Apt or Space # City/Province/State/Zip
Cell _____

Permanent Address: _____ Phone _____
Fax _____

Temporary/Local Address: _____ Phone _____
AT THIS ADDRESS UNTIL (DATE) _____

E-Mail Address: _____ Birth Date ____/____/____ Age: ____ Male Female
Month Day Year

Employer: _____ Occupation: _____

Address: _____ Phone _____

Marital Status: Single Married Separated Divorced Widowed

Spouse Name: _____ SS # _____ Birth Date: ____/____/____

Address: _____ Phone _____

Spouses Employer: _____ Occupation: _____

Address: _____ Phone _____

Responsible Party for Payment: _____ Relationship: _____

(NON-INSURANCE)

Address: _____ Phone _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone _____

Primary Care Physician: _____ Phone _____

Address: _____ UPIN #: _____

Referring Physician: _____ Phone _____

Address: _____ UPIN #: _____

ADVANCE DIRECTIVES—You have the right to prepare legal documents relating to: #1 your decision to refuse medical treatment you do not want; #2 requesting medical you do want; or #3 your ability to make medical decisions yourself.

Have you prepared any documents relating to the above 3 issues? YES NO
If yes, please provide a copy of the signed originals of the documents for inclusion in your medical files.

I understand that by proceeding with services I am responsible for payment of this account. The balance due may include deductibles, office visits, co-payments or other services not paid by insurance or other amounts determined to be patient responsibility. In the event of default, I also understand that collection costs and/or attorney fees may be charged to effect collection. Co-payments are due at time of service. Balances are due at time of billing.

Signature: _____ Date: _____
Patient or Responsible Party

INSURANCE INFORMATION

Please list all insurance coverages which you expect to be filed for payment of services provided to you. If there are more than two insurance companies providing coverage, please request an additional form from our receptionist.

If you change or have changed insurance companies, or you become eligible for another type of coverage during the course of your treatments, please notify one of our staff immediately!

Primary Insurance _____

Policyholder _____

Address _____

Relation to Patient _____

_____ city/state/Zip

Employer _____

Policy ID # _____ Effective Date ____/____/____

Phone _____

Group ID # _____ Local # _____

Second Insurance _____

Policyholder _____

Address _____

Relation to Patient _____

_____ city/state/Zip

Employer _____

Policy ID # _____ Effective Date ____/____/____

Phone _____

Group ID # _____ Local # _____

Prior Authorization Required? YES NO

Are You Eligible for Medicare? YES NO

Hospital Coverage Only? YES NO

Do You Have Medicare Part A Only? YES NO

Applied for AHCCCS/Medicaid? YES NO

Medicare Replacement HMO Policy? YES NO

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I hereby authorize *GORDON L GRADO, MD, INC* and/or *GRADO BRACHYTHERAPY, PC* to furnish information to my insurance carrier(s) concerning my illness and treatments.

I hereby assign payment direct to *GORDON L GRADO, MD, INC* and/or *GRADO BRACHYTHERAPY, PC* the surgical and/or medical benefits otherwise payable to me under the terms of my insurance. I understand that I am responsible for any amount not covered by insurance and that balances are due upon receipt of billing.

I hereby authorize photocopies of this form and my signature to be as valid as the original.

Signature: _____ Date: _____
Patient or Responsible Party

MEDICARE SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to *GORDON L GRADO, MD, INC* and/or *GRADO BRACHYTHERAPY, PC* for any services furnished me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Name: _____ ID#: _____

Signature: _____ Date: _____
Patient or Responsible Party

I authorize the Medicare Claim Administration to release to *GORDON L GRADO, MD, INC* and/or *GRADO BRACHYTHERAPY, PC* claim information for services provided to me by the above named provider(s).

Medicare # _____ Retired Railroad? YES NO

Hospital (Plan A) _____ Effective Date: ____/____/____ Medical (Plan B) _____ Effective Date: ____/____/____