COMCARE
comprehensive family health care
Salina Regional Health Center

Patient Demographics

Date_____ Preferred Doctor_____

Patient legal name _____
Last First Middle Suffix

Address_____City_____State_____ Zip_____
(must have a street address if PO Box is listed)

Social Security #_____Date of Birth_____ Sex_____ Marital Status: M S D W

Home #_____ Work #_____Ext_____ Cell # _____

Employer _____

Spouse_____ Date of Birth_____ Social Security #_____

Employer _____ Work # _____Ext_____ Cell # _____

Person who is responsible for the bill: _____
(if different from patient)
Address_____City_____ State_____ Zip_____

Home # _____ Work # _____ Cell # _____
Ext
Date of Birth _____ Social Security No _____ Employer _____

Emergency Contact_____ Relation_____

Home # _____Work # _____Cell # _____
Ext

INSURANCE

Primary Insurance Co _____Effective Date: _____Copay $_____

Address for claims_____
Mailing/PO Box City State Zip

ID # _____ Group # _____ Subscriber _____

Relationship _____ DOB: _____ Social Security #_____

Secondary Insurance Co _____Effective Date _____Copay $_____

Address for claims _____
Mailing/PO Box City State Zip

ID # _____ Group # _____ Subscriber _____

Relationship _____ DOB: _____ Social Security #_____

Assignment & Release

I, the undersigned, have insurance coverage and assign directly to SRHC and its affiliates all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Medicare Authorization:
I request that payment of authorized Medicare benefits be made either to me or on my behalf to SRHC and its affiliates for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Insured/Guardian Date