Northern Medical GROUP

Patient Name: _____ Account Number: _____

Date of Birth: _____ Social Security: _____ Gender: ☐ Male ☐ Female

Mailing Address: _____ City: _____ State: _____ Zip:_____

Street Address: _____ City: _____ State: _____ Zip:_____

Please check which phone number we can reach you at and leave a message.

☐Home Phone: _____ ☐Work Phone: _____ ☐Cell Phone: _____

Email Address: _____

Would you like to participate in our Patient Portal? ☐ Yes ☐ No

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____

Primary Care Provider: _____ Phone Number: _____

Employer Name: _____ Phone Number: _____

Pharmacy Name: _____ City: _____ State: _____

Mail Order Pharmacy Name: _____ Phone Number: _____

I grant permission to view my prescription history from external sources: ☐ Yes ☐ No

**Insurance Information:**

☐Commercial ☐Medicare ☐Medicaid ☐Worker's Compensation ☐No Fault ☐Other: _____

Primary Insurance: _____Policy # _____ Group # _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Address: _____ City: _____ State: _____ Zip: _____

☐Commercial ☐Medicare ☐Medicaid ☐Worker's Compensation ☐No Fault ☐Other: _____

Secondary Insurance: _____Policy # _____ Group # _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Address: _____ City: _____ State: _____ Zip: _____

☐Commercial ☐Medicare ☐Medicaid ☐Worker's Compensation ☐No Fault ☐Other: _____

Tertiary Insurance: _____Policy # _____ Group # _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Address: _____ City: _____ State: _____ Zip: _____

**Check all that apply:**

| **Student:** | **Employed:** | **Marital Status:** | **Ethnicity:** | **Race:** | **Language:** |
|---|---|---|---|---|---|
| ☐ Full Time | ☐ Full Time | ☐ Married | ☐ Hispanic or Latino | ☐ Black/African American | ☐ English |
| ☐ Part Time | ☐ Part Time | ☐ Single | ☐ Not Hispanic or Latino | ☐ White | ☐ Spanish |
| ☐ No | ☐ Retired | ☐ Divorced | ☐ Refuse to Report | ☐ Asian | ☐ Chinese |
| | ☐ No | ☐ Widowed | | ☐ Chinese | ☐ Polish |
| | | ☐ Separated | | ☐ Native Hawaiian | ☐ French |
| | | | | ☐ American Indian/Alaska Native | ☐ Russian |
| | | | | ☐ Other Pacific Islander | ☐ Italian |
| | | | | | Other: _____ |

**AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS, ADVANCED BENEFICIARY NOTICE**

I hereby authorize Northern Medical Group, PLLC (NMG) to apply for benefits on my behalf for covered services rendered by NMG. I request that payment from my insurance company be made directly to NMG. I certify that the information I have reported with regard to my insurance coverage is correct. This authorization may be revoked by either myself or my insurance company at any time in writing. If my insurance company denies payment for services provided by NMG, I authorize NMG to initiate an internal appeal, external appeal, and/or arbitration of the denied claim(s) on my behalf. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Please be advised that you will be responsible for any balance, in which your plan indicates is your responsibility, on their explanation of benefits EOB form, including, but not limited to non covered and not medically necessary services, All patients will be responsible for their copay, co-insurance and deductible. If we do not 'participate' with your plan, as a courtesy, we will send a claim to the carrier on your behalf. However, should they not pay your claim, you will be responsible for the full amount due. Should you receive payment directly from your insurance carrier, please forward it to our billing department.

Signature: _____ Date: _____