PATIENT DEMOGRAPHICS

NAME:____ Maritial Status:_____________

SEX:_____ DATE OF BIRTH:________________________ SSN#:_______________________________

EMAIL:____ (Email needed to access online portal)

ADDRESS:____ CITY:______________________________

STATE:___________ ZIP:___________________ EMPLOYER:____________________________________

HOME PHONE:_______________________________ CELL PHONE:________________________________

EMERGENCY CONTACT:________________________________ PHONE:__________________________

Can we leave a voicemail/send appointment reminders: Yes No

RESPONSIBLE/INSURED PARTY INFORMATION: *IF DIFFERENT FROM PATIENT*

NAME:____ DATE OF BIRTH:_______________

RELATIONSHIP TO PATIENT: _________________________________ PHONE:______________________

ADDRESS:____ CITY:______________________________

STATE:___________ ZIP:___________________ EMPLOYER:____________________________________

Medical Release Form

I hereby authorize Heelex LLC/JSPhyMgmt to disclose any necessary medical records from my visits to my primary care and/or referring physician that I have listed below.

PRIMARY CARE PHYSICIAN:____

REFERRING PHYSICIAN:____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize Heelex LLC/JSPhyMgmt to furnish any information needed by any insurance carrier to process any claim(s) for services rendered to the above-named patient. I assign benefits payable by the insurance carriers for those services to Heelex LLC/JSPhyMgmt. *I agree to be responsible for any amount and/or supplies not covered by insurance or for full amount if the above names patient does not have insurance.*

Patient Signature:____ Date:____________________