IMS

INTERNAL MEDICINE SPECIALISTS

201 North Buffalo Drive
Las Vegas NV 89145
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F: (702) 255-3170
www.IMSDoctors.com

PATIENT INFORMATION:

REFERRING DOCTOR: _____

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

DATE OF BIRTH: _____ **GENDER:** ☐ Male ☐ Female **SSN:** _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

ADDRESS: _____ **APT/SUITE:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PH: _____ **CELL PH:** _____

EMAIL: _____

PREFERRED METHOD OF COMMUNICATION:

☐ Mail ☐ Home Phone ☐ Cell Phone ☐ Other: _____

OK TO LEAVE MESSAGE ON HOME PHONE?
☐ Yes ☐ No

OK TO LEAVE MESSAGE ON CELL PHONE?
☐ Yes ☐ No

EMPLOYER: _____ **PHONE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMERGENCY CONTACT:

NAME: _____ **RELATION:** _____

PHONE: _____ **EMAIL:** _____

GUARANTOR INFORMATION:

If the primary insurance is through the parent/spouse, please complete this using their information.

NAME OF RESPONSIBLE PARTY: _____

DATE OF BIRTH: _____ **SSN:** _____

RELATIONSHIP: ☐ **Dependent** ☐ **Spouse** ☐ **Other:** _____

EMPLOYER: _____ **PHONE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____	**SECONDARY INSURANCE:** _____
MEMBER ID: _____	**MEMBER ID:** _____
GROUP NUMBER: _____	**GROUP NUMBER:** _____
GROUP NAME: _____	**GROUP NAME:** _____
CO-PAY: _____	**CO-PAY:** _____
SUBSCRIBER'S NAME: _____	**SUBSCRIBER'S NAME:** _____
SUBSCRIBER'S DOB: _____	**SUBSCRIBER'S DOB:** _____

HOW DID YOU HEAR ABOUT US? _____

☐ **FRIEND: Who shall we thank?** _____

☐ **DOCTOR: Who shall we thank?** _____

☐ **HOSPITAL** ☐ **ADVERTISEMENT** ☐ **WEBSITE** ☐ **ZOCDOC** ☐ **Other:** _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I authorize the release of medical and/or other information as necessary to process health insurance claims. I also request payment of benefits to my Provider when he/she accepts the assignment.

_____ _____

SIGNATURE **DATE**