# Family Medicine at Tallgrass
# Dr. Betsy A. Johns
# 601 SW Corporate View, Ste. 200
# Topeka, KS 66615

**Date:**_____

**Patient name:**_____
**Last** **First** **MI**

Address:_____City:_____State:_____Zip:_____

Employer/School:_____Primary Care Dr:_____

Home #:_____ Mobile #:_____ Work #:_____

Date of Birth:_____SS#:_____ Sex: M F Marital Status: S M W D

**Reason For Visit**:_____

**Emergency contact or name(s) of person(s) I give permission to discuss my health care:**

Name:_____Relationship:_____Phone #:_____

**Parent or guardian, if patient is minor/Person Responsible for Payment:**

Name:_____Street Address:_____

City:_____ State:_____ Zip Code:_____

Social Security Number:_____Date of Birth:_____Phone Number:_____

**PRIMARY INSURANCE INFORMATION** (If this is an auto accident this would be the auto insurance insurance):

Type of insurance:_____Name of insured:_____

Relationship to the patient:_____Date of Birth:_____Work #_____

Social Security Number:_____Employer_____

Address (if different from patient):_____

**SECONDARY INSURANCE INFORMATION** (Complete only if information is different than primary insurance):

Type of insurance:_____Name of insured:_____

Relationship to the patient:_____Date of Birth:_____Work #_____

Social Security Number:_____Employer_____

Address (if different from patient):_____

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

◇I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to Tallgrass Immediate Care. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or Intermediaries or carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying my treatment. (Section 1128 B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) **I authorize the release of my medical records to my referring physician and/or specialty physician as deemed necessary. I understand that my insurance may not cover all of my incurred charges and I accept full financial responsibility for any remaining balance.**

**◇I accept full responsibility for all charges incurred on this date.**

Signature:_____ Date:_____

Parent/Guardian (if patient is under age 18):_____