Patient Information Form

PAYANO, GLORIA

Integrative Medical Services PC

Print Date:2022-08-10

PATIENT INFORMATION

PATIENT'S NAME PAYANO, GLORIA		**ACCT/CHART#** 0000006243	
DOB 01/19/1971	**MARITAL** Married	**GENDER** Female	**SSN** ***-**-9468
ADDRESS 60 LEHRER AVENUE		**CITY** ELMONT	**STATE** NY **ZIP** 11003
HOME PHONE 646-756-0665	**WORK PHONE**	**MOBILE PHONE** 646-756-0665	
EMAIL GLORIAPAYANO@YAHOO.COM		**RACE** Declined to Specify	**OCCUPATION**
EMPLOYED	**EMPLOYER**	**ADDRESS**	
ATTENDING PHYSICIAN Islam, Mohammad S		**REFERRAL PHYSICIAN**	

FAMILY INFORMATION

KIN'S NAME		**RELATIONSHIP**	
DOB	**PHONE**	**SSN**	
ADDRESS	**CITY**	**STATE**	**ZIP**

EMERGENCY CONTACT

NAME	**RELATIONSHIP**	**PHONE**	
ADDRESS	**CITY**	**STATE**	**ZIP**

INSURANCE INFORMATION

NF/WC

INSURANCE ALLSTATE INSURANCE CO		**CLAIMANT** PAYANO, LUIS
RELATIONSHIP Spouse	**CASE TYPE** No-Fault	**CASE STATUS** Active
INITIAL VISIT DATE 01/01/1900	**CASE STOP DATE** 01/01/1900	
CLAIM# 0674662036		**POLICY#** 000000913923180
REPRESENTING ATTORNEY		**PHONE(ATTORNEY)**
ADJUSTER NAME	**ADJUSTER NUMBER**	
D.O.A. 06/13/2022 04:20	**CASE RELEATED TO**	**EMPLOYER**

Acknowledgement of HIPAA notice of privacy practices

I hereby acknowledge that I have fully reviewed and/or have received a complete copy of the HIPAA notice of privacy practices provided by the staff of this office.

Medicare / Medicaid Assignment of Benefits

I certify that the information given by me in applying for payment is correct.I authorize release of all records upon request.I request that payment of authorized benefits be made on my behalf.

Assignment of Insurance Benefit

I hereby authorize direct payment of medical benefits to **[Integrative Medical Services PC]** for services rendered by all medical providers in the corporation. I understand that I am financially responsible for any balance if my insurance is invalid.

RELATIONSHIP: DATE: