Patient Information Form

PAUTA, WILMER

Integrative Medical Services PC

ortho

Print Date:2022-08-10

PATIENT INFORMATION

PATIENT'S NAME PAUTA, WILMER		**ACCT/CHART#** 2486208	
DOB 12/25/1980	**MARITAL** Married	**GENDER** Male	**SSN** ***-**-1375
ADDRESS 37-36 79 STREET 1 FL		**CITY** JACKSON HEIGHTS	**STATE** NY **ZIP** 11372
HOME PHONE 718-440-5593	**WORK PHONE**	**MOBILE PHONE** 718-440-5593	
EMAIL		**RACE** Other Race	**OCCUPATION**
EMPLOYED	**EMPLOYER**	**ADDRESS**	
ATTENDING PHYSICIAN Islam, Mohammad S		**REFERRAL PHYSICIAN**	

FAMILY INFORMATION

KIN'S NAME		**RELATIONSHIP**	
DOB	**PHONE**	**SSN**	
ADDRESS 37-36 79 STREET		**CITY** JACKSON HEIGHTS	**STATE** NY **ZIP** 11372

EMERGENCY CONTACT

NAME	**RELATIONSHIP**	**PHONE** 718-440-5593	
ADDRESS 37-36 79 STREET		**CITY** JACKSON HEIGHTS	**STATE** NY **ZIP** 11372

INSURANCE INFORMATION

NF/WC

INSURANCE ALLSTATE INSURANCE CO		**CLAIMANT** PAUTA, WILMER
RELATIONSHIP Self	**CASE TYPE** No-Fault	**CASE STATUS** Active
INITIAL VISIT DATE 06/03/2022	**CASE STOP DATE** 01/01/1900	
CLAIM# 0671511137	**POLICY#** 000000978655903	
REPRESENTING ATTORNEY	**PHONE(ATTORNEY)**	
ADJUSTER NAME	**ADJUSTER NUMBER**	
D.O.A. 05/30/2022 00:00	**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: