NOBLEQUEST
A NON-PROFIT COMPANY

DATE: _____ / _____ / _____

PERSONAL INFORMATION

LAST NAME: ___________________ FIRST NAME: ___________________ M.I.: _____ SUFFIX: Jr. / Sr. / III

D.O.B: ___ / ___ / ___ SEX: M / F SSN: _____-____-______ WEIGHT: ________lbs. HEIGHT: ________ft.

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / SEPARATED

PREFFERED LANGUAGE: ______________ ETHNICITY: ___________________ RELIGION: ___________________

STREET ADDRESS: ____________________________ CITY: ___________________ STATE: _____ ZIP: __________

CELL: (_____) _____-_______ HOME: (_____) _____-_______ EMAIL: ____________________________

PREFERRENCE: CELL / HOME / EMAIL ADVANCE DIRECTIVE: Yes / No Last Reviewed: _____ / _____ / _____

EMERGENCY CONTACT NAME: _________________________________ RELATIONSHIP: ___________________

STREET ADDRESS: ____________________________ CITY: ___________________ STATE: _____ ZIP: __________

CELL PHONE: (_____) _____-_______ HOME PHONE: (_____) _____-_______

INSURANCE INFORMATION

INSURANCE NAME: ______________________________________ EFFECTIVE DATE: _____ / _____ / _____

SUBSCRIBER I.D./NO.: ____________________________ GROUP I.D./NO.: ___________________ (for HMO, IPA)

PRIMARY DOCTOR/PCP: ___________________ IPA/GROUP: ___________________ CO-PAY: $______________

EMPLOYEMENT INFORMATION

WORKING STATUS: EMPLOYED / UNEMPLOYED / RETIRED Date Last Worked: _____ / _____ / _____

EMPLOYER: ____________________________ PROFESSION / JOB TITTLE: ___________________

STREET ADDRESS: ____________________________ CITY: ___________________ STATE: _____ ZIP: __________

PHONE NUMNBER: (_____) _____-_______ FAX NUMBER: (_____) _____-_______

HEALTH & MEDICAL HISTORY

DO YOU SMOKE?: YES [ ] NO [ ] FREQUENCY: _____ STARTED: ___ / ___ / ___ QUIT: ___ / ___ / ___ List: ______________

DO YOU DRINK ALCOHOL?: YES [ ] NO [ ] FREQUENCY: _____ START DATE: ___ / ___ / ___ LAST DRINK: ___ / ___ / ___

ASSIGNMENT AND RELEASE

I, ___________________ (print) certify that I (or my dependent) have insurance coverage with my insurance and assign directly all insurance benefits, if any, otherwise payable to NobleQuest Health Foundation, Inc. for services rendered. I understand that I am financially responsible for all charges whether/or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of my benefits and the use of my signature on all insurance submissions.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to NobleQuest Health Foundation Inc. for any services furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefit payable for related services. I understand my signature request that payment be made and authorize release of medical information necessary to pay the claim. If 'other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown in Medicare assigned cases, the physician or supplier agrees to accept charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

AKNOWLEDGEMENT:

I, ________________________, (print) acknowledge that everything has been filled out to the best of my knowledge, with or without the assistance of a translator.

Signature: ____________________________ Date: _____ / _____ / _____

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