ADVANCED INTERNAL MEDICINE PRACTICE

AIM for better health

Patient information:

Last Name: _____ First Name: _____ Middle Initial:_____

Age:_____ Date of Birth:_____Sex:_____SSN:_____

Home Phone:_____Cell:_____Work:_____

Circle Preferred Contact: Home Cell Work

Address:_____City_____State____Zip:_____

Email Address:_____

Occupation:_____

Employer Name: _____

Referred by (we would like to thank them):

_____

Status (Circle one): Single Married Widow Divorced

Emergency Contact:

Name:_____Phone: _____Relationship:_____

Preferred Pharmacy:

Name:_____

Address: _____

Insurance Information:

Insurance Name: _____

Group #:_____Policy/ID #:_____

Policy Holder Name: _____DOB: _____SSN:_____

Relationship to patient:

☐ Parent ☐ Significant Other ☐ Sibling ☐ Other _____

Secondary Insurance :

Insurance Name: _____

Group #:_____Policy/ID #:_____

Policy Holder Name: _____DOB: _____SSN:_____

Relationship to patient:

☐ Parent ☐ Significant Other ☐ Sibling ☐ Other _____

I, the undersigned, certify that the above information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or the organization furnishing the services and authorize such physician or organization to submit a claim to Medicare or Insurance carrier on my behalf.

Patient /Guardian Signature:_____ Date: _____

14327 Blanco Rd.,
San Antonio, Texas 78216

Phone: (210) 245-7933
Fax: (731) 201-5068
www.aimprimarycaresa.com