Jones Medical Supply - New Patient Form

1. PATIENT INFORMATION

Acct #

Patient name: ______________________________ Date of Birth: __________ Social Sec #__________________

Home phone: ______________ CELL# ______________ Email address: ______________________________

Service address (where equipment is used): ____

City: ______________________________ St:______________ Zip:______________

Billing address (if different from above): ____

City: ______________________________ St:______________ Zip:______________

Next of kin: ____________________ Relationship: ______________ Alternate phone: ______________

2. PAYMENT INFORMATION

Primary Ins: ____________________ Policy #____________________ Effective date of this policy:

Insured Name: ____________________ Deductible amount: ______________

Secondary Ins: ____________________ Policy #____________________ Effective date of this policy:

Insured Name: ____________________ Deductible amount: ______________

Payment for CoPay & Deductible: ☐ Visa ☐ MasterCard ☐ Discover

*Card number*______________________________ *Exp Date* _____/______

CV2 code _____ *Billing Zip* ______________ *Name on card* ____________________

☐ Check by phone - routing #______________ acct# ______________

Routing # first 9 numbers printed on bottom of check. Account # (usually 10-12 digits) second set of numbers

office use only

____
amount paid

____
processed by / date

3. CPAP / BIPAP INFORMATION - if applicable

Where did you have your sleep study?____

Who is the doctor treating you for sleep apnea now?______________________________

When did you last receive a CPAP or BiPAP?______________________________________

Who was the company that provided your machine?__________________________________

Make and model of your current machine:____

What mask do you currently use?______________________________ Size ______________

4. AUTHORIZATION AND RELEASE

I authorize Jones Medical Supply, LLC (herein "Jones") to receive copies of all of my medical records, including, but not limited to progress notes, operative notes, laboratory results, sleep studies, prescriptions, and diagnostic tests. Disclosure of personal health information will be handled as outlined in Jones Current Notice of Privacy Practices. A photographic copy of this authorization shall be as valid as the original. This authorization is valid until cancelled in writing by either party. This release shall be valid while services are being rendered from Jones unless cancelled in writing. I further elect to choose Jones as my provider effective the date of this notice and authorize and direct any previous supplier, to release all documents to Jones relating to my prior service.

X______________________________________ ______________________

Patient's Signature Date

______________________________________ ______________________

If Patient is unable to sign, Personal Representative Signature Date