

Appt. Date: _____ Time _____ Doctor _____ Patient Acct# _____

PERSONAL INFORMATION (please print)

Name _____ DOB _____ Sex M/F Marital Status S M W D

Primary Address

Street _____ City _____ State _____ Zip Code _____
Second Address (What time of year are you at this address?) _____

Street _____ City _____ State _____ Zip Code _____

E-Mail Address _____ Cell Phone _____

Home Phone _____ Work Phone _____

Social Security _____ Driver's License # _____

Employer _____ Address _____

Family Physician _____ Who referred you? _____

Complete if under 18 years of age or a student: Parent/ guardian _____

Address _____ Phone _____ Work Phone _____

INSURANCE INFORMATION (please present card)

Insurance Co. _____ Policy Holder _____ Date of Birth _____

2nd Insurance _____ Policy Holder _____ Date of Birth _____

If your billing is handled by a third party (bank, trustee, etc.) please provide the following:

Name _____ Phone _____

Address _____ Phone _____

Person to notify in case of emergency _____ Phone _____

I authorize you to share appointment/billing/medical information with the following person/persons:

FINANCIAL ASSIGNMENT AND AGREEMENT

1. I request that payment of the authorized Medicare and/or insurance benefit be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents for any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
2. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize and assign to release all information needed to secure the payment.

Signed _____ Date _____