PATIENT INFORMATION

PATIENT NAME _____
(last) (first) (middle)

MAILING ADDRESS _____ CITY _____

STATE _____ ZIP _____ STATE YOU WERE BORN IN _____

DATE OF BIRTH _____ SEX* M / F MARITAL STATUS* M / D / S / W *** circle one**

RACE_____ETHNICITY_____ LANGUAGE_____

CELL PHONE # _____ HOME PHONE # _____

WORK PHONE #_____ EMPLOYER_____

REFERRED BY_____

PRIMARY INSURANCE CARRIER_____

BILLING ADDRESS_____ POLICY #_____

GROUP #_____ NAME OF POLICY HOLDER _____

D.O.B._____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE CARRIER_____

BILLING ADDRESS_____ POLICY #_____

GROUP #_____ NAME OF POLICY HOLDER _____

D.O.B._____ RELATIONSHIP TO PATIENT _____

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. Our office will file your insurance as a courtesy, however you are responsible for your co-pay and/or percentage which the insurance company is not liable for on the day of your visit. In the event your insurance company denies coverage and/or payment for charges you incur you are responsible for the balance due.
I have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf be paid to the physicians. I also authorize the release of any of my medical information to my insurance company as needed to issue benefits.

Signature_____ Date _____

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of my medical information to the Social Security Administration of its intermediaries or carriers for any Medicare related claim. I request the payment of benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services and whom submit a claim to Medicare for me.

Signature_____ Date _____ 3/2016