PATIENT INFORMATION (please print) Appointment Date _____/_____/_____

Name_____ Account # _____
Last First Middle Initial
Mailing Address_____
Apt or Box # City State Zip
Home Phone ( )_____ Cell or Work Phone (____)_____ Employer Name_____
Occupation _____

Date of Birth ____/_____/____ Age _____ Sex _____ Marital Status _____ SS# _____

RESPONSIBLE PARTY (if different form the patient or insured)

Name _____
Last First Middle Initial
Mailing Address_____
Apt or Box # City State Zip
Home Phone (___)_____Cell or Work Phone (___)_____ Employer Name _____

Date of Birth _____/____/_____ Age ____ Sex _____ Marital Status _____ SS # _____

I agree to be responsible for services provided that my insurance carrier may deem "not medically necessary"

INSURANCE INFORMATION please present insurance card at the time of check in or THIS SECTION MUST BE FILLED IN

Primary Insurance Name_____ **Secondary** Insurance Name_____

Ins. Address_____ Ins. Address_____

Name of Insured_____ Name of Insured_____

Insured Address_____ Insured Address_____

DOB ___/___/___ Sex ____ Marital Status _____ DOB ___/___/___ Sex ___ Marital Status_____

Insured ID # _____ Insured ID # _____

Group # _____ Group # _____

Employer Name _____ Employer Name _____

Employer Address _____ Employer Address _____

Employer Phone ( )_____ Employer Phone ( )_____

Relationship of Patient to Insured _____ Relationship of Patient to Insured _____

Other family members that are patients _____

In case of emergency, who should be notified? _____ Phone ( )_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date ___/___/___

Do we have permission to: Leave a message on your answering machine at home? Y / N
Leave a message at your place of employment? Y / N
Leave a message with your spouse? Y / N
May we call you at work? Y / N
Discuss your medical condition with any member of your household? Y / N

If Yes, whom _____ Relationship _____

Phone # (day) ( )_____ Evening # ( )_____

May we E-mail personal medical information to you? Y / N

E-mail Address _____

Patient Signature _____ Date _____

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This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself of the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Patient Signature _____ Date _____
signature as it appears on Medicare Card

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits of the benefits payable for related services.

Patient Signature _____ Date _____
signature as it appears on Medigap card