PATIENT INFORMATION

NAME ____
(FIRST) (MI) (LAST)

ADDRESS ____
(STREET) (CITY) (ST) (ZIP)

HOME PHONE # (____) ______________ WORK PHONE # (____) ______________

SOCIAL SECURITY # ______________ BIRTHDATE ______________ SEX ________

SPOUSE NAME ______________ WORK PHONE # ______________

WHO WILL BE RESPONSIBLE FOR YOUR MEDICAL BILLS? SELF SPOUSE GUARDIAN

ARE YOU PRESENTLY EMPLOYED? ______ NAME & ADDRESS OF EMPLOYER ______________

____

IS YOUR SPOUSE EMPLOYED? ______ NAME & ADDRESS OF EMPLOYER ______________

____

**WE ASK THAT ALL PATIENTS PAY THEIR BILLS IN FULL ON EVERY VISIT. WE WILL FILE INSURANCE CLAIMS AS A COURTESY. YOU WILL BE REFUNDED IF YOUR INSURANCE COMPANY PAYS FOR A VISIT YOU HAVE PAID FOR. PLEASE DIRECT YOUR QUESTIONS TO OUR INSURANCE SECRETARY.

WOULD YOU LIKE FOR US TO FILE YOUR INSURANCE CLAIM FOR YOU? YES NO

PLEASE COMPLETE THE FOLLOWING INFORMATION IF YOU WANT US TO FILE YOUR INSURANCE CLAIMS FOR YOU.

PRIMARY INSURANCE ____

ADDRESS TO SEND CLAIMS ____

NAME OF INSURED ______________ DOB ________ RELATIONSHIP - SELF / SPOUSE / CHILD

ID # ______________ GROUP # ______________

DOES YOUR INSURANCE REQUIRE PRECERTIFICATION FOR HOSPITALIZATION? ______________

SECONDARY INSURANCE ____

ADDRESS TO SEND CLAIMS ____

NAME OF INSURED ______________ DOB ________ RELATIONSHIP - SELF / SPOUSE / CHILD

ID # ______________ GROUP # ______________

FOR TRICARE

ID CARD # ______________ ISSUE DATE ________ EXPIRATION ________

CARD HOLDER'S NAME ______________ SOC. SEC. # ______________

SPONSOR BRANCH OF SERVICE ______________ RANK ______________

SPONSOR STATUS: ACTIVE DUTY RETIRED DECEASED

(OVER)

WHO REFERRED YOU TO OUR OFFICE ______________________________

IN CASE OF EMERGENCY, PLEASE NOTIFY ______________________________

PHONE # ____________________ WORK # ____________________ RELATIONSHIP ____________________

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PLEASE READ THE FOLLOWING STATEMENT AND REFER YOUR QUESTIONS TO THE STAFF.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO BE RELEASED TO MY INSURANCE COMPANY OR 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 OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. REGULATIONS PERTAINING TO MEDICAL ASSIGNMENT BENEFITS APPLY.

PATIENT/GUARDIAN SIGNATURE ______________________________ DATE ____________________