

(PLEASE PRINT)

**PATIENT INFORMATION**

NAME		DATE	
ADDRESS	CITY	ZIP	
HOME PHONE	BUSINESS PHONE	SOCIAL SEC. NO.	
DATE OF BIRTH	AGE	SEX M F	MARITAL STATUS S M W D SEP.
REFERRED BY	PERSONAL PHYSICIAN		
PATIENT'S EMPLOYER	POSITION		
BUSINESS ADDRESS	SPOUSE'S EMPLOYER		

**PERSON RESPONSIBLE FOR BILL**

(IF OTHER THAN ABOVE)

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
ADDRESS (IF OTHER THAN ABOVE)	SEX M F	HOME PHONE
EMPLOYER	SOCIAL SEC. NO.	POSITION
BUSINESS ADDRESS		BUSINESS PHONE

**INSURANCE, MEDICARE, WORKER'S COMPENSATION or WELFARE INFORMATION**

MEDICARE NO. \_\_\_\_\_ NAME OF POLICY HOLDER: \_\_\_\_\_  
 MEDICAID NO. \_\_\_\_\_

COMPANY OF PROGRAM	GROUP NUMBER/FECA	POLICY NUMBER
1.		
2.		
3.		

**NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY**

NAME	RELATIONSHIP TO PATIENT
ADDRESS	HOME PHONE
EMPLOYER	BUSINESS PHONE
POSITION	

**AUTHORIZATIONS**

**BENEFITS TO PHYSICIAN:**  
 I hereby authorize payments directly to the physician of the surgical and/or medical benefits.  
 I also understand I am responsible for any portion of my bill not covered by my insurance company.

SIGNED \_\_\_\_\_ (Patient or Parent if Minor)

**RELEASE OF INFORMATION:**  
 I hereby authorize release of information for insurance claim purposes.  
 Photostat of the above is as valid as the original.

I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations.

Date \_\_\_\_\_ 20 \_\_\_\_\_ Signed \_\_\_\_\_ (Insured Person)