

Date: \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Name:			
Street Address:	City:	State:	Zip:
Home phone #: ( )	Alternate #: ( )	Date of Birth	Age:
Social Security #:	Circle Sex: M F	Marital Status:	Race:
Patient's Employer:		Occupation:	
Contact in Case of Emergency:		Phone #:	
Family Doctor:		Referring Doctor:	
Last	First	Last	First
	Phone		Phone

**INSURANCE INFORMATION**

<b>Primary Insurance:</b>	<b>Phone #:</b>
Insurance Address:	
City:	State: Zip:
Insured Name:	Relation to Patient:
Subscriber ID#	Group ID#:
Insured DOB:	Insured Employer: Insured SS#:
Insurance coverage provided through: <input type="checkbox"/> Employer <input type="checkbox"/> Individual Policy <input type="checkbox"/> Self Pay	
<b>Secondary Insurance:</b>	<b>Phone #:</b>
Insurance Address:	
City:	State: Zip:
Insured Name:	Relation to Patient:
Insured Policy ID#:	PT Policy #: Group #:
Insured DOB:	Insured Employer: Insured SS#:
Insurance coverage provided through: <input type="checkbox"/> Employer <input type="checkbox"/> Individual Policy <input type="checkbox"/> Self Pay	
If Medicare is secondary circle reason: working spouse has insurance Veteran disabled other:	

**If Patient is a Minor: Please complete page two of this form in addition to below**

Mother's Name:	Date of Birth:	Home Phone #:
Mother's Employer:	Bus. Phone #:	Social Security #:
Father's Name:	Date of Birth:	Home Phone #:
Father's Employer:	Bus. Phone #:	Social Security #:

**Please read and sign below:**

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize my physician to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to my physician on claims for which they have accepted assignment, and I authorize the physician to submit a claim to Medicare for payment on my behalf. I request that payment under the medical insurance program be made to my physician on any bills for services furnished me by my physician for which they have accepted assignment. I further release my physician to release medical information concerning my treatments to my insurance carrier(s) and I authorize payment of medical benefits from those carriers to be made directly to my physician on claims for which they have accepted the assignment. I also understand that I am responsible for payment for services not covered by my Insurance Plan.

I also authorize my physician's office to provide my medical information to other organizations or entities for the determination and payment of benefits. I authorize my physician's office to permit my insurance companies or third party payors to review/audit my medical chart if they so request. I assign benefits otherwise payable to me my physician, I understand that I am financially responsible for the charges for any services rendered to me by my physician(s).

I have received a copy of this physicians practice **PRIVACY POLICY**.

Signature:

Date:

## **AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS**

By law, any child under the age of 18 years old cannot be seen by a doctor without the consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that his person has been appointed by you to act on your behalf.

This is a legal document. With it you may appoint anyone who is over the age of 18 years of age to be responsible for your child when you are unable to accompany them to their medical appointment.

Please complete the following section(s):

Name of Minor: \_\_\_\_\_  
DOB: \_\_\_\_\_

I, \_\_\_\_\_ being the parent or legal guardian of the above named minor, do here appoint the following person(s) to act in my behalf in authorizing medical care for the above named minor.

Name	Address	Phone
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I, \_\_\_\_\_ being the parent or legal guardian of the above named minor, give my permission for \_\_\_\_\_ to be seen by Dr. \_\_\_\_\_ for their follow-up appointment(s) in my absence.

Please be advised that we will not be able to perform any invasive procedures or prescribe any medications unless a parent or legal guardian accompanies the minor to their appointment.

If such services need to be performed, another appointment will need to be scheduled in which the parent must be in attendance.

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

Signature of Parent/Guardian	Date
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