PATIENT INFORMATION

PLEASE PRINT

PATIENT Cell # ( ) _____

Last_____First_____MI____ Home ( ) _____

Patient's Home Address_____ City_____State_____Zip_____

Patient's Billing Address_____City_____State_____Zip_____

Social Security #_____Date of Birth_____Age_____Drivers License #_____

Patient's Employer_____Work Address_____Work #_____

Spouse's Name_____Spouse's Employer_____Work # _____

Emergency Contact:
(Local Friend or Relative)Name_____Address_____Phone #_____

REFERRED TO THIS OFFICE BY:_____

WHO IS YOUR PRIMARY PHYSICIAN?_____PHONE #_____

INSURANCE: PLEASE LIST ALL HEALTH CARE INSURANCE COMPANIES WHICH COVER PATIENT:

PRIMARY: Insurance Company Name_____Policy #_____

Policy Holder's Full Name_____DOB_____

Policy Holder's Employee Name & Address_____

Policy Holder's Phone #_____Policy Holder's Work #_____

SECONDARY: Insurance Company Name_____Policy #_____

Policy Holder's Full Name_____DOB_____

Policy Holder's Employer Name & Address_____

Policy Holder's Phone #_____Policy Holder's Work #_____

Medicare #_____(Please Include Letter)

Medicaid #_____

Please remember that insurance a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid by your insurance.

PLEASE READ & SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to **DR ANTOSH** and understand that I am financially responsible for all charges whether or not paid by insurance including fees associated with collections for unpaid balances. I hereby authorize the doctor to release all information necessary to secure the agreement shall be valid as the original.

SIGN HERE _____ **DATE** _____