PATIENT INFORMATION

NAME, FIRST_____M.I._____ LAST_____
MARITAL STATUS:_____
SOC.SEC.#_____-_____-_____ EMPLOYER:_____
DATE OF BIRTH:_____/_____/_____ GENDER:_____
HOME ADDRESS:_____
_____

EMAIL ADDRESS:_____

PHONE #: _____ _____ _____
CIRCLE PREFERRED #: HOME# WORK # MOBILE #

IS IT OK TO LEAVE A DETAILED MESSAGE? **YES/NO**

MAY RELEASE MEDICAL INFO. TO: (names of family members/guardian)_____,
_____,_____,_____,_____

EMERGENCY CONTACT:_____PHONE #:_____
SPOUSE:_____PHONE #:_____
CARETAKER:_____PHONE #:_____

SEASONAL ADDRESS: (IF APPLICABLE)_____
_____

GUARANTOR: PERSON FINANCIALLY RESPONSIBLE (a.k.a. Guarantor) IF DIFFERENT THAN PATIENT

GUARANTOR NAME:_____
GUARANTOR ADDRESS:_____
_____
INSURANCE:_____
SUBSCRIBER NAME:_____D.O.B._____/_____/_____
(SUBSCRIBER IS PRIMARY PERSON WHO HOLDS INSURANCE IF DIFFERENT THAN SELF)
RELATIONSHIP TO SUBSCRIBER:_____
(EX. SPOUSE, CHILD, OTHER)

ASSIGNMENT OF BENEFITS:
I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRAITON (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 MEDICARE ASSIGNMENT OF BENEFITS ONLY APPLY. I GIVE CONSENT TO HAVE PHOTOGRAPHS TAKEN FOR MY RECORD.
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 BY BEHALF FOR ANY SERVICES FURNISHED TO ME. I AUTHORIZE ANY HOLDER OR MEDICAL INFORMATION TO RELEASE TO THE ABOVE MEDIGAP CARRIER ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

PLEASE SIGN HERE:_____ **DATE:**_____/_____/_____