

PATIENT INFORMATION

PATIENT NAME _____

PERMENANT ADDRESS _____

LOCAL ADDRESS _____

PHONE: Home _____ Work _____ Cell _____

SEX M ___ F ___ DATE OF BIRTH _____ AGE _____

MARITAL STATUS M ___ S ___ D ___ W ___ SPOUSE NAME _____

PATIENT SOCIAL SECURITY _____ - _____ - _____

OCCUPATION _____

EMPLOYER _____

EMPLOYER ADDRESS _____

EMERGENCY CONTACTNAME _____ RELATIONSHIP _____

EMERGENCY CONTACT PHONE NUMBER _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

PHARMACY _____ PHONE# _____

INSURANCE INFORMATION

INSURANCE COMPANY #1

COMPANY NAME _____

INSURED NAME _____

ID# _____ GROUP # _____

PRIMARY INSURED: SELF _____ SPOUSE _____

SPOUSE SOCIAL SECURITY _____ - _____ - _____

SPOUSE EMPLOYER _____ SPOUSE DATE OF BIRTH _____

INSURANCE COMPANY #2

COMPANY NAME _____

ADDRESS _____

INSURED NAME _____

ID# _____ GROUP # _____

1. I have read and agreed to abide by the office policies of Diabetes & Thyroid Care Center of Excellence.
2. I agree to pay \$ 25.00 fine if I am unable to keep my appointment and unable to reschedule or notify the office 24 hours in advance.
3. I am personally responsible for charges not covered by the insurance.
4. If my insurance requires a referral, it is my responsibility to get it from my Primary care doctor. If I am seen without a valid referral, I will be personally responsible for the charges.
5. I permit a copy of authorization to be used in place of the original and request payment of insurance benefits either to myself or to the party who accepts assignment.

PATIENT SIGNATURE

DATE