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 $ 50.00 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