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Submit by Email | Print Form

Patient information and assignment of benefits

Name

Address

City | State | Zip Code

Home Phone: | Cell Phone: | Work Phone:

Social Security Number: | E-mail: | Date of Birth:

Employer: | Referred from:

Insurance:

☐ Medicare — Medicare Number

☐ Medicaid — Medicaid Number

☐ Other insurance - primary

Name

Address

City | State | Zip Code

Policy Number: | Group Number:

Subscriber/policyholder: | Subscriber's Birth Date:

Subscriber's employer: | Relationship to Patient:

☐ Other insurance - secondary

Name

Address

City | State | Zip Code

Policy Number: | Group Number:

Subscriber/policyholder: | Subscriber's Birth Date:

Subscriber's employer: | Relationship to Patient:

I authorize release of any and all information to my insurance companies or Medicare/Medicaid and permit a copy of this authorization to be used in place of the original. I authorize my doctor to act as my agent to assist in obtaining payment from my insurance companies and authorize payment directly to my physician or to the party who accepts assignment. I understand that I am responsible for my billing including co-payments and deductibles. In the event of non-coverage, I agree to assume responsibility for payment if Medicare or insurance payment is denied.

Patient's SIGNATURE _____ Date

version 9/5/2009