PATIENT INFORMATION:

Name: _____ Date of Birth _____
Last First Middle initial Mo. Day Year
Sex: F M Social Security #: _____-_____-_____ Marital status: S M D W
Home Address: _____ Tel: ( ) _____
Street apt.
_____
City State Zip

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Employment:

Employer: _____ Occupation: _____
Address: _____ Tel: ( ) _____
(Number and Street)
_____
City State Zip

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Who to notify in case of emergency:

Name: _____ Relationship: _____
Address: _____ Tel: ( ) _____
Street Apt Work Tel: ( ) _____
_____
City State Zip

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Insurance information:

Insurance company name: _____
Address: _____ Tel: ( ) _____
(Street and number)
_____ Effective date: _____
City State Zip
Name of insured: _____ Insured ID #: _____

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ASSIGNMENT OF BENEFITS

I, _____, hereby authorize _____
Name of patient Name of insurance carrier
to make payment directly to Dr. _____ for any medical and/or surgical benefits otherwise payable to me. I hereby acknowledge that I shall be solely authorized to designate the physician to perform the requested medical services beginning as of this date.
I understand that I am financially responsible for any charges not paid by my insurance company.
I am of legal age and legally competent to make this agreement.

Date: _____ _____
Patient's Signature