

PATIENT INFORMATION

Patient's Name _____ M.I. _____ Date of Birth: ___/___/19___

Social Security # _____ Age _____ Sex M/F _____ Marital Status S M W D

Full Address: _____ Apt: _____

City : _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Email: _____

Employer: _____ Address: _____

Occupation: _____ Work #: _____ RETIRED: YES NO

Name & # of Primary Care Physician: _____

Who may we thank for referring you to us (If Medical Doctor please provide the telephone number?)

INSURANCE INFORMATION-PRIMARY

If you are **not** the policy holder please provide the Guarantor's information

Ins. Company: _____ Policy #: _____ Group/Plan#: _____

Name of Guarantor: _____ Relationship: _____

Address of Guarantor's Employer: _____ Work#: _____

Insured's SS#: _____ Insured's DOB: _____

SECONDARY INSURANCE

Ins. Company: _____ Policy #: _____ Group/Plan#: _____

Name of Guarantor: _____ Relationship: _____

Address of Guarantor's Employer: _____ Work#: _____

Insured's SS#: _____ Insured's DOB: _____

IS YOUR VISIT RELATED TO A WORKER'S COMPENSATION OR NO FAULT?

Yes _____ No _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. Meere, all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above-named doctor and/or supplier of services in this office to release any medical or other information necessary to process this claim. I authorize the use of this signature on all submissions.

Signature of Responsible Party/Patient _____ Date _____