

P a t i e n t B i l l i n g I n f o r m a t i o n

Patient Name: _____ Date of Birth ___/___/___ M___ F___
Address: _____ City/State/Zip: _____
Phone: (____) _____ Soc. Sec. # ___/___/___ Driver's Lic# _____ State___
Employer: _____ Phone :(____) _____ Occupation: _____
Employer Address: _____ City/State/Zip: _____
School (if minor) _____ City/State Phone: (____)

PRIMARY INSURANCE

SECONDARY INSURANCE

Insured Name (if different from patient): _____ DOB ___/___/___
Ins Co Name: _____ Ins. Co. Name: _____
Ins. Co. Address: _____ Ins. Co. Address: _____

Insured's Employer: _____ Insured Soc. Sec. #: ___/___/___
Relationship to Policy Holder: _____
Group/Policy #: _____ Group/Policy #: _____
Attorney Name: _____ Phone: (____) _____
Address/City/State/Zip: _____

GENERAL INFORMATION

Local Relative: _____ Relationship: _____
Address: _____ City/State/Zip: _____
Phone: (____) _____ Referred By: _____ Phone: (____) _____
Family Physician: _____ Phone: (____) _____
Person legally responsible for payment of this account: _____
I agree to accept responsibility for all charges incurred. I understand that a 48-hour notice of cancellation is required to avoid a charge
Signed: _____ Date: ___/___/___

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance company to make payment directly to my physician surgeon and/or associates or assistants for services rendered.

Signature: _____ Date: ___/___/___
Address _____
City/State/Zip _____

Witness: _____ Date: ___/___/___