PATIENT'S INDEX 06/07/2017

Patient: _____ | Responsible party: _____
|
Name: _____ | Name: _____
|
Adr: _____ | Adr: _____
|
CSZ: _____ | CSZ: _____

Birthdate: _____ Age: _____ Sex: ____ Marital: ____ S.S.#: _____

Home Ph#: _____Cell: _____Work Ph#: _____

E-mail Address: _____
Race: _____ Ethnicity: _____
Language Pref: _____ Contact Pref: _____ (Home, Work, Cell, Email)
Ref Dr1:_____
Ref Dr2:_____

RP Employer:_____

Emergency Contact & Ph#: _____

Spouse: _____ Father: _____

Pharm: _____ Mother: _____

---------- 1st Insurance coverage ----------

Name: _____ Pol#: _____ Grp#: _____
Holder: _____ Bplan: _____
Adr: _____

Sex: _____ Birth Date: _____ Phone#: _____

Relation to Insured: _____ Send Claims to: _____

Employer: _____
---------- 2nd Insurance coverage ----------

Name: _____ Pol#: _____ Grp#: _____
Holder: _____ Bplan: _____
Adr: _____

Sex: _____ Birth Date: _____ Phone#: _____

Relation to Insured: _____ Send Claims to: _____

Employer: _____
0 ----------
RELEASE OF BENEFITS AND INFORMATION: I AUTHORIZE MY INSURANCE BENEFITS PAID DIRECTLY TO THE MEDICAL PROVIDER OR OTHER PRACTITIONER OR SUPPLIER OF SERVICES. I AM FINANCIALLY RESPONSIBLE FOR ALL BALANCES DUE. I AUTHORIZE THE MEDICAL PROVIDER, INS COMPANY OR OTHER HEALTH CARE PROVIDER TO RELEASE ANY REQUESTED INFORMATION FOR CLAIMS. FORM 0702-11 (01/15)

Signature: _____