DATE _____

BASIC INFORMATION & FINANCIAL DATA

PLEASE PRINT

Patient's Name_____
First M.I. Last

Date of Birth _____ **S.S.#** _____

Circle Correct Information Sex: Male Female Status: Single Married

Mailing Address _____**City/St/Zip**_____

Phone _____ **Cell Phone**_____

Person Responsible for Acct._____ **Cell Phone** _____

Relationship to Patient_____ **D.O.B.**_____**S.S.#**_____

Patient Employed by _____**Occupation**_____

Bus. Address_____ **Bus. Phone**_____

Spouse Name _____**Employed by**_____

Bus. Address _____ **Bus. Phone** _____

Emergency Contact _____ **Phone** _____

Please list all members living in your household

Name Relationship Age

_____

_____

_____

Has any family member been seen in our office? _____**If yes, Name**_____
Referred by _____

GIVE COPY OF INSURANCE CARD TO FRONT DESK

I authorize the release of any medical or other information necessary to process my claims or referrals. I also request payment of government benefits (if a Medicare patient) either to myself or to the party who accepts assignment. As a PPO or HMO patient, I hereby assign benefits to Dr. Feray.
I agree that I am responsible for payment in full for all services rendered to me or my dependents regardless of insurance company reimbursements. I further agree that if, as a PPO or HMO patient, I fail to provide this office with correct insurance information ON THE DATE OF SERVICE, that I will be personally responsible for payment of all charges for myself or my dependents.

Signed _____

DATE _____

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