PATIENT INFORMATION

Last Name _____First Name _____ Middle_____

Address _____ City _____ State_____ Zip _____

Phone ( )_____ SS# _____ Birth date _____ Age_____

Insured Name Name_____

Insured SS# _____ Insured Birth date _____ Employer _____

COPY FRONT AND BACK OF INSURANCE CARD HERE:

I, the undersigned directly assign to [PROVIDER NAME] all medical benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Insured/Guardian Date

INITIAL DIAGNOSIS

1) _____

2) _____

3) _____

4) _____

Dr.'s Initials _____

MEDICARE ONLY

PART? _____

DATE OF EXAM _____

Fax to: 724/387-2456