Patient Information

Patient Name:_____
First MI Last

Address:_____

City:_____ State:_____ Zip:_____

SS#:_____/_____/_____ Date of Birth:_____ Male / Female

Home Phone:_____ Work:_____ Cell:_____

Email: _____ Marital Status:_____ Student status: Non/FT/PT

Patient Employer:_____ Address:_____
Street City/ State/ Zip

Emergency Contact:_____ Phone:_____ Relation to Patient:_____

Referring Physician:_____ Office Number:_____

Primary Physician: _____ Office Number _____

Pharmacy Name:_____ Phone:_____

Insurance Information

(This is the order in which it will be filed to your insurance company)

Primary Insurance Name:_____

Subscriber Name:_____Date of Birth:_____Relation to Patient:_____

Policy Number:_____Group:_____

Employer:_____Phone:_____SS#:_____/_____/_____

Secondary Insurance Name:_____

Subscriber Name:_____Date of Birth:_____Relation to Patient:_____

Policy Number:_____Group:_____

Employer:_____Phone:_____SS#:_____/_____/_____

GUARANTOR INFORMATION

(Complete if different than above information)

Name:_____Date of Birth:_____Phone Number:_____

As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility. Payment is expected at the time of service unless arrangements have been made with the office manager.

Patient's Authorization and Assignment of Benefits:

I authorize the release of any medical information necessary to process this claim and I authorize payment of surgical and medical benefits directly to Dr. John M. Moore. I understand that regardless of insurance benefits, if any, I am financially responsible for the fees for services rendered. I am also responsible for obtaining referrals (if needed), certification, or second opinion's which may be required under my insurance policy. I have completed this form the best to my knowledge.

Signature_____Date:_____

*****Medicare Patients Only, Please See Below*****

Please read carefully: I understand that Medicare may not pay for services rendered.

Signature_____Date:_____