

PATIENT INFORMATION

FULL NAME (LAST, FIRST, MIDDLE) _____ DATE OF BIRTH _____

CURRENT ADDRESS _____ YEARS THERE _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

SOCIAL SECURITY NO. _____ REFERRED BY _____

PRESENT EMPLOYER _____ TITLE _____

WORK PHONE _____ x _____ ADDRESS _____

EMERGENCY CONTACT _____ PHONE _____

a copy of your insurance card will be needed at the front desk

POLICYHOLDER INFORMATION

FULL NAME (LAST, FIRST, MIDDLE) _____ DATE OF BIRTH _____

CURRENT ADDRESS _____ YEARS THERE _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

SOCIAL SECURITY NO. _____

PRESENT EMPLOYER _____ TITLE _____

WORK PHONE _____ x _____ ADDRESS _____

EMERGENCY CONTACT _____ PHONE _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

SIGNED (GUARDIAN IF MINOR) _____ DATE _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services.

SIGNED (GUARDIAN IF MINOR) _____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize Bellevue Family Practice P.C. to release any information acquired in the course of my examination or treatment for insurance and consultation purposes only.

SIGNED (GUARDIAN IF MINOR) _____ DATE _____

FINANCIALLY RESPONSIBLE I understand that I am financially responsible for the amount of my bill which is not paid by my insurance. If I have no insurance coverage I am fully responsible at the time of service for the entire amount of the bill.

SIGNED (GUARDIAN IF MINOR) _____ DATE _____