

Patient Information

Date: _____

Patient's Name: _____

Address: _____ Apt. # _____

City/State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Bus. Phone: _____

Male _____ Female _____ Age: _____ Date of Birth: _____ Marital Status: _____

Social Security Number: _____

Emergency Contact Name and Number: _____

ALLERGIES: _____

Name of Referring Physician: _____ *Name of Primary Physician: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: _____

Insurance Information

Private Medicare Medicaid Social Security Compensation No Fault

Name of Insurance Co: _____

Name of Insured: _____ Social Security: _____

Group Number: _____

Identification Number: _____ Date of Birth: _____

Patient Relationship: Sel f: _____ Spouse: _____ Child : _____ FT Student: _____

Secondary Insurance: Insured Person: _____ DOB: _____

Social Security No: _____ Identification Number: _____ Group Number: _____

Insured's Employer _____

Business Address: _____ Phone: _____

Please turn over...form continued on back.

Please remember that insurance is considered a method of reimbursement to the patient and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the fee charges. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of my medical records as requested by insurance carriers.

PLEASE READ THE FOLLOWING STATEMENT AND THEN HAVE THE PATIENT GUARANTOR (the person responsible for the patient's billing) SIGN IT.

I understand that Dr. Stanley Pollak will, if I request, take my insurance on assignment as payment for this patient's bills. I do understand and agree that my insurance company shall send all payments directly to Dr. Stanley Pollak. In the event that the insurance company sends the payment to me by mistake, I agree to immediately inform the doctor and turn over a payment that belongs to the doctor.

SIGNATURE: _____

AUTHORIZATION TO PAY INSURANCE BENEFITS

I understand that I am financially responsible for all charges not covered by this authorization. I hereby authorize payment directly to the above named physician or his/her billing organization, otherwise payable to me but not to exceed the regular charges for the services provided.

Signature

Date

MEDICARE

Name of Beneficiary

Health Insurance Claim Number

I request that payment of Medicare benefits be made on my behalf to the physician named above for services rendered to me. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature

Physician Signature

Date

Date

