

**PATIENT INFORMATION**

(Please print, and answer all questions)

LAST NAME: \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: M  F  MARITAL STATUS: S  M  D  W

EMPLOYER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CAN MESSAGES REGARDING MEDICAL RESULTS BE LEFT ON YOUR ANSWERING MACHINE? Y  N

**SPOUSE OR PARENT INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**IN CASE OF EMERGENCY NOTIFY:**

NAME: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURED: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ID # OF POLICY: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

INSURANCE COMPANY ADDRESS: \_\_\_\_\_

SECONDARY INSURED: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ID # OF POLICY: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

INSURANCE COMPANY ADDRESS: \_\_\_\_\_

Due to the complex interrelationships and mergers between the insurance companies, it is impossible for us to determine whether we are participating in any specific health plan. For example, Blue Cross Blue Shield has over 100 different insurance plans with various requirements and different panels of participating physicians. For this reason, and to avoid any misunderstandings, we request that you contact your specific health plan to see if we are listed as participating providers. When contacting your insurance carrier, please record the name of your insurance representatives as well as the date and time you spoke with that representative to avoid any future misunderstandings.

**INSURANCE AUTHORIZATION & ASSIGNMENT**

I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and / or surgical benefits to Dr. Peron and Fleming. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Insured Signature \_\_\_\_\_ Date \_\_\_\_\_