PATIENT INFORMATION

DATE_____ (Please Print)

PATIENT'S

FULL NAME_____BIRTH DATE_____

Single_____Married_____Widowed_____Divorced_____Minor_____Sex: M or F (Circle)

ADDRESS_____

(Street Address, City, State, Zip)

PHONES: HOME_____BUSINESS_____CELL_____

OCCUPATION_____EMPLOYER_____

RESPONSIBLE PARTY/BILLING ADDRESS INFORMATION
(Fill Out if Different From Patient Information)

NAME_____RELATIONSHIP TO PATIENT_____

ADDRESS_____

(Street Address, City State, Zip)

PHONES: HOME_____BUSINESS_____CELL_____

OCCUPATION_____EMPLOYER_____

PRIMARY INSURANCE INFORMATION

NAME OF INSURED_____BIRTH DATE_____

INSURED'S SOCIAL SECURITY #_____MEDICARE #_____

INSURANCE CO._____

CERTIFICATE/POLICY/ID #_____GROUP #_____

INSURANCE ADDRESS_____

SECONDARY INSURANCE

NAME OF INSURED_____BIRTH DATE_____

INSURANCE CO._____

CERTIFICATE/POLICY/ID #_____GROUP #_____

INSURANCE ADDRESS_____

EMERGENCY CONTACT_____PHONE_____

AUTHORIZATION: I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical insurance and Medicare benefits to Alexander Miller, M.D. I authorize Dr. Miller to take and use my patient photographs for charting, medical education and publication.

SIGNATURE: _____Patient – Parent – Guardian (Circle)

REFERRED BY:_____