CLINIC

PATIENT INFORMATION FORM

DATE

PATIENT NAME (FIRST) (MIDDLE) (LAST) DOB / /

HOW DO YOU WISH TO BE ADDRESSED?

ADDRESS CITY STATE ZIP

MARTIAL STATUS HOME PHONE CELL PHONE S.S. #

WHICH PHYSICIAN ARE YOU HERE TO SEE?

EMPLOYER OCCUPATION EMPLOYER PHONE

EMPLOYER ADDRESS CITY STATE ZIP

IN CASE OF EMERGENCY WHO SHOULD WE CONTACT? NAME ADDRESS/PHONE

SPOUSE'S NAME (FIRST) (MIDDLE) (LAST)

SPOUSE'S DOB SOCIAL SECURITY NUMBER

SPOUSE'S EMPLOYER OCCUPATION PHONE

EMPLOYER ADDRESS CITY STATE ZIP

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

IF YOU ARE A STUDENT, PLEASE GIVE YOUR PARENT'S NAME AND ADDRESS

INSURANCE INFORMATION — Please present insurance card at time of appointment.

NAME OF PRIMARY INSURANCE COMPANY PHONE #

ADDRESS TO FILE CLAIMS CITY STATE ZIP

NAME OF POLICY HOLDER DOB SS# EFFECTIVE DATE

IDENTIFICATION NUMBER GROUP NUMBER

NAME OF SECONDARY INSURANCE COMPANY PHONE #

ADDRESS TO FILE CLAIMS CITY STATE ZIP

NAME OF POLICY HOLDER DOB SS# EFFECTIVE DATE

IDENTIFICATION NUMBER GROUP NUMBER

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Ruch Clinic to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the Physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. In the event of default for any charges incurred, I agree to pay all costs of collections, including reasonable attorney fees. I authorize use of this form on all my insurance companies.

DATE ______________________ SIGNATURE ______________________________

FPS 30654