Office Use

F/C : ❑ INS ❑ MC ❑ MD ❑ SP ❑ WC ❑ AA ❑ PI J#

Included : ❑ Insurance Card Copy ❑ Employer Claim Form ❑ Referral

PATIENT INFORMATION

Thank you for choosing PHYSICIANS PLUS. In order to help us complete records and submit accurate bills to your insurance company, please assist us by providing the following information :

Today's Date : _____ Patient's Soc. Sec. # : _____

First Name : _____ M.I. : _____ Last Name : _____

Date of Birth : _____ ❑ Male ❑ Female Are you pregnant? ❑ Yes ❑ No

Mailing Address : _____

Zip Code : _____ City : _____ State : _____

Cell Phone : (_____)_____ Work Phone : (_____)_____

Employer : _____ Occupation : _____

INSURANCE PATIENTS

Please complete the following section and present your Insurance Cards.

	PRIMARY INSURANCE	SECONDARY INSURANCE
Relation to Insured:	❑ Self ❑ Spouse ❑ Child ❑ Other	❑ Self ❑ Spouse ❑ Child ❑ Other
Complete the following Insured information if *RELATION* is other than *SELF*.		
Insured's Name:		
Insured's Birthdate:		
Insured's Social:		
Male or Female:		
Employer:		
Complete the following Insured information if it differs from the Patient's.		
Insured's Address:		
City, State, Zip:		
Phone Number:	( )	( )

ACCIDENT PATIENTS

CLAIM FILING INFORMATION	
WORK COMP OR MEDPAY INFORMATION	*ATTORNEY INFORMATION*
Date of Injury:	
Insurance Carrier Name:	Name :
Carrier Address:	Address :
City, State, Zip:	City, State, Zip :
Adjuster's Name:	Contact :
Adjuster's Phone : ( )	Phone : ( )
Claim Number:	File No. :

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process Insurance claims by provider or agent. I understand that I am responsible for all charges which may include legal fees, collection fees, and 1% per month interest on past due balances, or other expenses incurred by the provider in collecting my account. I hereby orde accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Patient Signature : _____ Date : _____