PATIENT INFORMATION

Name: _____ DOB: ____/____/____
Last First M.I.

Address: _____
Street

_____
City State ZIP

Home Phone: _____ SSN: _____ - _____ - _____

Bus. Phone: _____ Cell Phone: _____

Employer: _____ Position: _____

Religion: _____ Ethnic Background: _____

MEDICAL INSURANCE INFORMATION

Primary Insurace _____ Subscriber: _____

Membership Number: _____ Effective Date: _____

Group Code: _____ Coverage Code _____

Secondary Insurance _____ Subscriber: _____

Membership Number: _____ Effective Date: _____

Group Code: _____ Coverage Code: _____

Spouse's Name _____ DOB: ____/____/____

Employer: _____ Business Phone: _____

Position: _____ SSN: _____ - _____ - _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Phone: _____

Address: _____
Street Apt# City State ZIP

Relationship to Patient: _____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, services rendered and to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents.

I, _____, hereby authorizes my insurance company to pay and hereby assign directly to Dr. Thomas Kosasa all benefits, if any, otherwise payable to me for his services as described on the provider's claim. I understand I am financially responsible for all charges incurred. I understand that I will be fully responsible for the deductible or non-covered services that I incur.

Guarantor's Signature: _____ Date: _____