PAUL M. PUZISS, M.D., P.C.

PATIENT INFORMATION

Patient Name:_____ Home Phone_____
First MI Last

Address:_____

City:_____ State_____ Zip_____ Marital Status: S M W D

Date of Birth:_____ Age:___ Social Security No:_____ Drivers License No:_____

Male [ ] Female [ ] Employer:_____ Occupation:_____

Employers Address:_____ Work Phone:_____

Referred By (Physicians Full Name)_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Was illness or injury connected with patient's employment? Yes [ ] No [ ] Motor Vehicle Accident: Yes [ ] No [ ] Date of injury:_____

IF YOUR INJURY IS EMPLOYMENT/ WORK RELATED/or MVA - a separate form is required

[SPOUSE] / [PARENT] (circle one)

Name:_____ Home Phone:_____
First MI Last

Address (if different from patient)_____

Date of Birth:_____ Social Security No:_____ Employer_____

INSURANCE INFORMATION **(complete information is required)**

Primary Ins._____ ID No:_____ Group No:_____

Insurance Co. Address:_____

Subscriber Name:_____ Date of Birth:_____ Relationship to Patient_____

Does your insurance require you to obtain a Referral / Authorization from your PCP? Yes [ ] No [ ]

Secondary Ins._____ ID No:_____ Group No:_____

Insurance Co. Address:_____

Subscriber Name:_____ Date of Birth:_____ Relationship to Patient_____

IN CASE OF EMERGENCY

Name of friend or relative NOT living with you:_____ Phone:_____

IF YOU HAVE RETAINED AN ATTORNEY REGARDING YOUR INJURY

Name of Attorney:_____ Phone:_____

Address:_____

AUTHORIZATION TO RELEASE INFORMATION / ASSIGNMENTOF BENEFITS / AGREEMENT / CONTRACT

I hereby authorize Paul M. Puziss, M.D., P.C. to release to the insurance company(s) and/or attorney named above any information acquired in the course of my examination or treatment (if patient is a minor, parent or guardian must sign).

I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign to Paul M. Puziss, M.D., P.C. any and all insurance and settlement benefits due me to the full extent of my financial obligation to said clinic.

I understand my insurance company is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment for charges incurred. 1 understand that a monthly $5.00 rebill fee will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

SIGNED:_____ DATE:_____

Signature Required