PATIENT INFORMATION

Patient Name: ____________________ Date of Birth: ____________ Sex: M F

Address: ____

Street Box# City State Zip

Telephone ( ) ____________________ Social Security # ____________________

Relationship to Responsible Party: ☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Other

Family Doctor: ____________________ Referring Doctor: ____________________

Responsible Party: ____________________ Spouse Name: ____________________

Address: ____
(if different from that of patient)

Telephone ( ) ____________________ Social Security # ____________________

Employer Name & Address: ____

Employer Telephone #: ____

Spouse Employer Name & Address: ____

Spouse Employer Telephone #: ____

In Case of Emergency Notify: ____________________ Telephone #: ____________________

Fill in only if you have Welfare:

Welfare Case Number: ____________________ Please Check: ☐ OH ☐ WV ☐ PA

Caseholder Name: ____

Primary Insurance: ____________________ Identification #: ____________

Insurance Address: ____________________ Group #: ____________

Policyholder Name: ____________________ Relationship to Patient: ____________

Secondary Insurance: ____________________ Identification #: ____________

Insurance Address: ____________________ Group #: ____________

Policyholder Name: ____________________ Relationship to Patient: ____________

MEDICARE AUTHORIZATION STATEMENT

I request that payment of authorized Medicare benefits be made either to me or to the above designated physician or provider for any services furnished by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits payable for related services.

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Date Signature

AUTHORIZATION TO RELEASE/ASSIGNMENT OF BENEFITS

I authorize Dr. Tamboli the holder of medical and other information about me to release to Federal, State and Local government, commercial or privately sponsored health insurance program, or their intermediaries or carriers, any information needed for this and any other related claim. I further request that payment of authorized benefits be made of my behalf. I assign the benefits to be payable to the physician or other provider furnishing the services

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Date Signature