

PATIENT INFORMATION – PLEASE COMPLETE BOTH SIDES OF THIS FORM

Please circle the name of the physician your appointment is with:

James F. Freeman, M.D.
Michael L. Wertheimer, M.D.

Hal B. Wright, M.D.
Theresa K. Cassidy, O.D.

John M. Freeman, M.D.

W. David Irvine, M.D.

						Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
Last Name	First Name	Middle	Marital Status	Date of Birth	Age	Social Security	Race
Street Address		City	State	Zip	County	Home Area Code/Phone	Cell Area Code/Phone
Email Address			Responsible Party, Phone and Address (If other than Patient)				
Emergency Contact		Relationship	Area Code/Phone		Address		
Patient Employer	Employer Address			Work Area Code/Phone		Occupation	
Name of Spouse	Spouse Employer			Work Area Code/Phone		Occupation	

INSURANCE INFORMATION

Medicare Policy Number	Name of Primary Care Physician	Physician Phone	Physician Address, City, State, Zip	
Insurance Company Name	Address	Phone	Policy No.	Program Sponsor
Insurance Company Name	Address	Phone	Policy No.	Program Sponsor

In order to control billing costs, we request that office visits be paid at time services are rendered. The following authorization release is needed for completing insurance claims. Please sign.

I request that payment of authorized insurance benefits be made on my behalf to my physician for any services furnished me by that provider.
I authorize any holder of medical information about me to release to my insurance company or its agents any information needed to determine these benefits or the benefits payable for related services.

**Remember to
Complete Both Sides**

—————→

Patient's Signature

Date

