

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.

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

Date Signature

Date Signature