

PATIENT INFORMATION

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME PHONE: () _____ SEX: _____ MARITAL STATUS: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NO.: _____

EMPLOYED BY: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

CITY _____ STATE _____ ZIP _____ PHONE# _____

HOW WERE YOU REFERRED TO THIS PRACTICE? _____

SPOUSE INFORMATION

NAME: _____ PHONE: _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH: _____ SOCIAL SECURITY NO.: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ EMPLOYER PHONE: _____

CITY _____ STATE _____ ZIP _____

NEAREST RELATIVE (NOT LIVING WITH YOU): _____ PHONE: _____ RELATIONSHIP TO YOU: _____

INSURANCE INFORMATION

Insurance Company Name	Policyholder (Subscriber)	Policy Number or Certificate Number
1. _____	_____	_____
2. _____	_____	_____

FOR MINORS ONLY: (Parent or Legal Guardian)

FATHER'S NAME: _____	ADDRESS: _____
PHONE: () _____	EMPLOYER/ADDRESS: _____
SOCIAL SECURITY NO.: _____	EMPLOYER PHONE# _____
MOTHER'S NAME: _____	ADDRESS: _____
PHONE: () _____	EMPLOYER/ADDRESS: _____
SOCIAL SECURITY NO.: _____	EMPLOYER PHONE# _____

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE THE RELEASE OF ANY INFORMATION ACQUIRED DURING MY EXAMINATION AND TREATMENT.

Signed _____

ASSIGNMENT OF BENEFITS

I CERTIFY THAT THE SERVICES LISTED HAVE BEEN RECEIVED AND I AUTHORIZE PAYMENT TO BE MADE TO THE PHYSICIAN.

Signed _____

MEDICARE ASSIGNMENT

I REQUEST THAT PAYMENT UNDER THE MEDICARE INSURANCE PROGRAM BE MADE TO ME OR ON MY BEHALF TO A. RANDALL MOODY, II M.D. FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN AND I AUTHORIZE ANY HOLDER OR MEDICARE INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION (MEDICARE) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

Patient's Name _____ Date _____

I have completed this form fully and completely, and certify that I am the patient or duly authorize general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

Preferred Method of Payment: Cash Check Credit Card (MasterCard / Visa)

Date (today) _____

Signature of Patient, or Parent, or Responsible Party _____