

Welcome to our office!

Patient Name: _____ Date of Birth: _____

Address _____ City _____ Zip _____

Home Phone: _____ Cell phone: _____

Email address: _____ May we send &/or leave information? ___yes ___no

Marital Status: Single Married Divorced Widow Gender: female male

Occupation: _____ Employer: _____ Work Phone _____

INSURANCE INFORMATION:

Primary insurance co.: _____ Policy holder's Name: _____

ID#: _____ DOB: _____ Relationship to patient: _____

Secondary insurance co.: _____ Policy holder's Name: _____

ID#: _____ DOB: _____ Relationship to patient: _____

IF someone other than the patient is responsible, PLEASE COMPLETE:

Responsible Party: _____ Relationship: _____

Home address: _____ Phone: _____

City _____ State _____ ZIP _____

INSURANCE AUTHORIZATION: Our office will file insurance claims for all reimbursable services.

PLEASE remember that you are responsible for all deductible, copay and non-covered services.

I authorize the release of any medical information necessary to process my claim.

SIGNATURE: _____ Today's date: _____

I also authorize payment directly to Dr. Bourhill for his services. I understand that I am responsible to acquire referrals/authorizations required by my insurance plan. I will be fully responsible for any claim denied because a referral/authorization was not on file. I am personally responsible for the full fee of all services rendered to me.

SIGNATURE: _____ Today's date: _____