

PATIENT AND INSURANCE INFORMATION

Patient's Full Name: _____

SSN#: _____ DOB: _____ Age: _____ Gender: M F

Status: Single Married Widowed Divorced | Spouse's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

E-mail: _____

Employer: _____ Occupation: _____

How did you hear about us? _____

Emergency Contact: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

PRIMARY INSURANCE:

Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's SS #: _____ DOB: _____

Patient's Relationship to Subscriber: Self Spouse Child Other: _____

SECONDARY INSURANCE:

Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's SS #: _____ DOB: _____

Patient's Relationship to Subscriber: Self Spouse Child Other: _____

Assignment of Benefits: It is customary to pay for all services on the date rendered unless other arrangements were made before your appointment. The patient/guarantor is responsible for deductibles, co-pays, non-covered services, other services that are not considered medically necessary, as well as any other fees in accordance with insurance contracts. I hereby assign all medical benefits to which I am entitled. I hereby authorize my insurance carrier(s), including Medicare to issue payment directly to Costus Medical.

I hereby acknowledge that I am fully responsible for payment as listed above.

Patient or Patient's Representative Signature

Date