James R. Meyer M.D. P.A.

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PATIENT INFORMATION SHEET

Patient Full Name: _____ *Date of Birth:* _____ *Age:* _____

Social Security Number: _____-_____-_____ *Marital Status:* _____

Mailing Address: _____

Phone Home: _____ *Work:* _____ *Cell:* _____

Email Address: _____.

INSURANCE DETAILS: Insurance Company: _____ *Co Pay:* _____

Full Name of the Main person on Insurance _____

Social Security Number of Main Subscriber: _____

Date of Birth of the Main Insurance Subscriber: _____

Relationship to the patient being seen today: Mother: _____ *Father:* _____

OR Other: _____*(Explain).*

Main Subscribers mailing address: _____

City: _____ *State:* _____ *Zip:* _____

Main Subscribers Phone Number: _____.

PLEASE PROVIDE A COPY OF THE INSURANCE CAR AND ALL INSURANCE INFORMATION AND DRIVERS LICENSE AND PHOTO ID.

I authorize the release of any medical or other information necessary to process this claim to third party payers and or other health practitioners.

I authorize and request my insurance company to pay directly to this physician group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I AUTHORIZE THE RELEASE OF MY MEDICATON HISTORY TO DR. JAMES R. MEYER BY ANY PHYSICIAN OR PHARMACY.

SIGNED: _____ DATE: _____