DANISH
(PLEASE ANSWER IN ENGLISH)
GIV VENLIGST SVAR PA ENGELSK

BAYVIEW GENERAL MEDICINE

CELL PHONE___________________

DATO_________________ HJEMME TELEFON NO.____________________

PATIENT____

ANSVARLIGE PERSON (HVIS 18 AR) ____

ADRESSE____

BY____________________LAND_____________________________POST NO.____________________

SEX ( ) MALE ( ) FEMALE ALDER_________ FϕDSELSDAG______________________________

ENLIG ________ GIFT _______ ENKE _______ SKILT ________DIVORCED__________

PATIENTENTS ARBEJDSGIVER & NO.____

AEGTEFAELLES ARBEJDSGIVER & NO.____

GRUNDEN TIL BESϕGET____

HUEM ER ANSVARLIG FOR BETALINGEN____

HVAD ER DE TIL PATIENTEN____

PERSON NO.____

HVILKEN FORM FOR BETALING ____________CASH____________MC/VISA__________AMEX

HAR DE FORSIKRINGSSELSKAB______ENJ_______YA (HVIS JA)

NAVN AF FORSIKRINGSSELSKAB____

NAVN OF ANDET FORSIKRINGSSELSKAB____

I TIL FAELDE AF UHELD RING TIL____________________TELEFON NO.______________________

HVOR HϕRTE DE OMOS____

EMAIL ADDRESS____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I ________________hereby authorize ________________________ to pay and hereby assign directly to Richard W Blanchar M.D. all benefits, otherwise payable to me for his services as described on the attached forms. I understand that I am financially responsible when received by and paid to_______________________ will be credited to my account, in accordance with the above said assignment.

UNDERSKRIFT_______________________________________ DATO__________________________________

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