

FRENCH
PLEASE ANSWER IN ENGLISH
ANTWOORD IN ENGELS INIEN MOSELYK
BAYVIEW GENERAL MEDICINE

HUIS TELEFOON _____
TELEFOON _____
DATUM _____
PATIENT NAMB _____
VERANTWOORDELYKE PARTY _____
STRAATNAAM _____
PLAATS _____ LAND _____ POSTCODE _____
SEX () MALE () FEMALE LEEFTYD _____ GEBOORTE DATUM _____
ALLEENSTAAND _____ GETROUWD _____ WEDUWE _____ APART _____ GESCHEIDEN
PATIENT NUMMER _____
SPOUSE EMPLOYER & NUMBER _____
REDEN VAN BEZOEK _____
WIE IS VERANTWOORDELIJK WOOR DE REEKENING _____
RELATIE TOT PATIENT _____
SOFI NUMMER _____
HOW DO YOU INTEND TO PAY _____ CONTANT _____ MC/VISA _____ AMEX
BENT U VERZEKERD _____ NEE _____ JA (INDIEN JA)
NAAM VERZEKERAAR _____
NAAMVAN TWEEDE VERZEKERAAR _____
IN GEVAL VAN NOOD BELLEN OF CONTACT _____ TELEFOON# _____
HOE HEEFT ONS LEREN KENNEN _____
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.

HANDTEKENING _____ DATUM _____

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