SERBO CROATIAN
PLEASE ANSWER IN ENGLISH

BAYVIEW GENERAL MEDICINE

KUCNI TEMEFON_____

DATUM_____ **CELL PHONE_____**

IME PACIJENTA_____

KO JE ODGOVORAN (ZA MALOLETNIKE) _____

ADRESA ULICA I BROJ_____

GRAD_____DRZAVA_____POSTANSKI BROJ_____

POL ( ) MALE ( ) FEMALE STAROST_____ DATUM RODJENJA_____

SAMAC/A _____ OZENJEN/A _____ UDOVAC/A _____ ODVOJEN/A _____RAZVENDEN/A

GDE STE ZAPOSLENI I BROJ TELEFONA_____

GDE JE SUPRUG/A ZAPOSLEN/A I BROJ TELEFONA_____

RAZLOG POSETE_____

KO JE ODGOVORAN ZA PLACANJE RACUNA_____

SRODSTVO SA PACIJENTOM_____

SOCIJALNI BROJ (S.S.#) SUPRUG_____

KAKO NAMERAVATE DA PLATITE _____NOVCEM_____MC/VISA_____AMEX

DALI IMATE ZDRAVSTVENO OSIGURANJE_____NE_____DA(AKO IMATE)

IME PRVOG OSIGURANJA_____

IME DRUGOG OSIGURANJA_____

U SLUCAJU HITNE POTREBE ZVATI_____BROJ TELEFONA_____

KAKO I GDE STE CULI O NAMA_____

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.

POTPIS_____ DATUM_____

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