SWEDISH
PLEASE ANSWER IN ENGLISH

BAYVIEW GENERAL MEDICINE

TEMEFON HEM_____

DATUM_____ **CELL PHONE_____**

PATIENT NAME_____

MALSMAN (OM MINDERARIG) _____

GATUADRESS_____

STAD_____LAND_____POSTNR_____

SEX ( ) MALE ( ) FEMALE ALDER_____ FADELSEDATUM_____

GIFT _____ KON OGIFT _____ DIVORCED _____ SEPARATED _____ANKA/ANKLING

ANSTALLNINGSNR FRANSKILD_____

SPOUSE EMPLOYER & NUMBER_____

ANLEDNING TILL BESOUET_____

VEM ANSVABAR FOR RAUNINGEN_____

FORHALLANDE TILL PATIENT_____

SOCIAL SECURITY #_____

HUR VILL DU BETALA_____KONTANT_____MC/VISA_____AMEX

DO YOU HAVE MEDICAL INSURANCE_____NO_____YES (OM JA)

NAMN PA OSTE FORSAKRINGSTAGARE_____

NAMN PA ANDRE FORSAKRINGSTAGARE_____

OM EN NODSITUATION UPPSTAR NOTERA_____TELEFONNR_____

VA FICK DU HORA TALAS OM PRAUTIK_____

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.

SIGNATURE_____ DATUM_____

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