BAYVIEW GENERAL MEDICINE

HOME PHONE_____

DATE_____ CELL PHONE_____

PATIENT NAME_____

RESPONSIBLE PARTY (IF MINOR) _____

STREET ADDRESS_____

CITY_____STATE_____ZIP_____

SEX ( ) MALE ( ) FEMALE AGE_____ BIRTHDATE_____

MARRIED _____ SINGLE _____ DIVORCED _____ SEPARATED _____WIDOWED

PATIENT EMPLOYER & NUMBER_____

SPOUSE EMPLOYER & NUMBER_____

PURPOSE OF VISIT_____

WHO IS RESPONSIBLE FOR ACCOUNT_____

RELATIONSHIP TO PATIENT_____

SOCIAL SECURITY #_____

HOW DO YOU INTEND TO PAY _____CASH_____MC/VISA_____AMEX

DO YOU HAVE MEDICAL INSURANCE_____NO_____YES (IF YES)

NAME OF PRIMARY INSURER_____

NAME OF SECONDARY INSURER_____

IN CASE OF EMERGENCY NOTIFY_____PHONE#_____

HOW DID YOU LEARN OF OUR PRACTICE_____

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_____ DATE_____