GERMAN
PLEASE ANSWER IN ENGLISH

BAYVIEW GENERAL MEDICINE

TELFON, ZUMAUSE__________________

DATUM_________________ **CELL PHONE____________________**

PATIENT NAME____

VERANTWORTUNG (MINDREJAHRIG) ____

STRASSE____

STADT____________________LAND____________________________POSTLEITAHL_________________

SEX ( ) MALE ( ) FEMALE ALTER_________ GEB______________________________

ALLEINLEBEND ________ VERHEIRATET _______ WITVE __________GETRENT _______

GESCHIEDEN ________

PATIENT BEREF + NR.____

URSACHE FUR DEN RESUGH____

VERANTWORTUNG FUR DEN KONTO____

WHO IS RESPONSIBLE FOR ACCOUNT____

RELATION ZUR PATIENT____

SOCIAL SECURITY #____

MOCHTEN SI ZAHLEN ____________BAR____________MC/VISA__________AMEX

HABEN SIE KRANKEN VERSICHERUNG______NEIN_______JA (JA IF JA)

VERSICHERUNGS GESCHELLSCHAF____

NAME OF SECONDARY INSURER____

IM NOTFALL INFORMATION____________________TELFON#_______________________

WHOHER KENNEN SIE MEINE PRAXIS____

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.

GERMAN

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UNTERSCHRIFT_______________________________________

DATUM__________________________________