# **James Sherman, M.D.** Tower Gastroenterology

Today's Date

| Account No. | Patient Last Name | First Name | M.I. |
|---|---|---|---|
| | | | |

| Street Address | Apt. # | City, State | Zip Code |
|---|---|---|---|
| | | | |

| Sex | Birth Date | Age | Social Security Number | Home Telephone Number |
|---|---|---|---|---|
| | | | | |

If patient is Minor, Guardian's Full Name

| Your Regular Physician's Full Name | Office Telephone Number |
|---|---|
| | |

| Referred By | Telephone Number |
|---|---|
| | |

## Emergency Notification

Drivers License # Name: Relationship:

| Street Address | Apt. # | City, State | Zip Code |
|---|---|---|---|
| | | | |

## Employment Information

Employer Name: Work Telephone:

| Street Address | Apt. # | City, State | Zip Code |
|---|---|---|---|
| | | | |

## Insurance Company (Primary)

code: Name: Member or Medicare Number

Address:

Group No. Subscriber Name(If Not Patient) REL.

## Insurance Company (Secondary)

Code: Name: Member or Medicare Number

Address:

Group No. Subscriber Name(If Not Patient) REL.

## Third Party Billing (or Remarks)

Third Party Name

Address:

- AUTHORIZATION TO PAY -

I, _____hereby authorize _____to pay directly to Jeffrey H. Sherman, M.D. the surgical and or medical benefits, if any, otherwise payable for his services as described on my insurance form hereof, but not to exceed the charges for those services. I understand that I am financially responsible for those charges not paid by my insurance company.

Date:_____ Signed: _____