PATIENT INFORMATION

Name:_____
Last *First* *M.I.*

Date of Birth: ____/____/____ Age: _____ Sex: ___ Male ___ Female

ADDRESS:

Mailing Address _____
City *State* *Zip*

Summer Address _____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ e-mail: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____Date of Birth: ____/____/____
Last *First* *M.I.*

Address:_____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

INSURANCE CARRIER INFORMATION: ___Medicare replacement ___ HMO

Primary Insurance Carrier: _____
Secondary Insurance Carrier: _____

INSURANCE AUTHORIZATION- TO BE KEPT ON FILE

Office policy requires payment in full at time of service unless other arrangements are made or insurance coverage is in effect. You are ultimately responsible for all charges for medical treatment and services, including all copayments, coinsurance and deductible amounts dictated by your policy. In order that we may assist you in filing for your insurance benefits, we request that you authorize Stacia Poole, MD, LLC to bill the above insurance companies for services rendered, and also that you agree to assign benefits and authorize payment for such services directly to Stacia Poole, MD, LLC. With your signature below, you give permission for release of any information needed to process your insurance claims and you allow a copy of this authorization to be used in place of the original . It is your responsibility to be familiar with the requirements and benefits of your particular insurance plan, including any copayments or requirements for preauthorization for services, and to assist us in complying with such requirements. You agree to notify the office if there is a change in coverage and provide new identification cards for review.

Date: ____/____/____ Signature: _____

Please provide your insurance card(s) and driver's license to the receptionist along with this form.