

CARROLL ARTHRITIS, P. A.

TODAY'S DATE:

PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS THAT APPLY

Patient Name: Last: _____ First: _____ Initial: _____

Street: _____

City: _____ State: _____ Zip: _____

Home Phone: #() _____ Work Phone: #() _____ Sex: Male Female

Date of Birth: _____ SSN#: _____ Marital Status: S M D W

Employer: _____ Employer Address: _____

Spouse (Parent if Minor): _____ Spouse/Parent Home Phone: #() _____

Spouse/Parent Work Phone: #() _____ Spouse/Parent Address: _____

In case of emergency, name of person not living with you: _____

Emergency Contact _____

Home Phone: #() _____ Relationship: _____ Work Phone: #() _____

Family Doctor/PCP Name: _____ Phone: #() _____

Family Doctor/PCP Address: _____

Name of Referring Physician if Applicable: _____

Phone # () _____

Address _____

BILLING AND INSURANCE INFORMATION

Is your illness/injury related to work, your job, a motor vehicle accident or any other type of accident which may end up in court or for which you will seek compensation from a third party? YES NO (If yes, please see the receptionist before filling out any further information.)

Primary Insurance Company Name: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Social Security #: _____

Employer: _____ Work Phone: #() _____

Secondary Insurance Company Name: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Social Security #: _____

Employer: _____ Work Phone: #() _____

I hereby authorize Carroll Arthritis, P.A. to apply for benefits on my behalf for covered services for my insurance company(ies), and request payment be made directly to the above named provider.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any other related claim, to the above named billing agent, (or in case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

Office Use Only:
Account Number

Signature of Subscriber or Beneficiary