

COQUELET & PUNGER FAMILY MEDICINE, P.A.

Patient Name: _____
Last First Middle

Address: _____

Zip: _____ City: _____ State: _____

Home Phone: () _____ Pt's. Work () _____

Date of Birth: _____ Social Security #: _____

Marital Status Married Divorced Widow Single (never married)

Employment: Company: _____

Address: _____ City: _____ State: _____

Emergency Contact (not living in your home) _____ Phone: _____

Pt's. Cell () _____ Pt's. Pager () _____

Spouse's Name: _____ Spouses Work #: _____

Driver's License or State ID # _____

E-Mail (Home): _____

E-Mail (Work): _____

Employment Status Full Time Part Time Retired Not Employed Student

INSURANCE INFORMATION: _____ (We Will Need a Copy of Your Insurance Card)

Primary Ins. Co. Name: _____

Group #: _____ Ins ID #: _____

Subscriber's Name: _____ Relationship: _____

Subscriber's SS#: _____ Subscriber's D/O/B _____

Secondary Ins. Co. Name: _____

Group #: _____ Ins ID #: _____

Subscriber's Name: _____ Relationship: _____

Subscriber's SS#: _____ Subscriber's D/O/B _____

Who can we thank for this referral? _____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the Physician to release any information acquired in the course of my care for treatment, payment or health care operations.

(Patients Signature)

PAYMENT AUTHORIZATION

I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photo static copy of this authorization will be as valid as the original.

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he/she remains personally responsible for payment. As a courtesy, however, we will prepare and submit any necessary claim forms, reports and itemizations to assist in making collections from insurance companies and will credit any such collections to the patient's account.

I further understand that if my account remains outstanding for more than 30 days, my account will be placed with a collection agency and I will be responsible for the 30% collection rate charged by that agency for collection of my debt.

I have been given an opportunity to view and have if requested, a copy of a "Notice of Privacy Practice", supplied by this office.

Signature of Patient: _____ Date: _____