

Date: _____

Account Number: _____

PATIENT INFORMATION

Patient Name: _____ Middle Init. _____ Age: _____

Address: _____ Cell Phone: (____) ____ - _____

City: _____ State: _____ Zip: _____ Home Phone: (____) ____ - _____

Birthdate: Month _____ Day _____ Year _____ Sex: _____ Marital Status: _____

Social Security Number: _____ - _____ - _____ Are you a student?: Yes No

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Work Address: _____ Work Phone: (____) ____ - _____

IF PATIENT IS A MINOR

Responsible Party's Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____ - _____

REFERRED BY: Physician Friend Other _____

Name: _____

Address: _____ Phone: (____) ____ - _____

INSURANCE INFORMATION

Primary Insurance Co.: _____

Address: _____

Policy (ID) Number: _____ Group Number: _____

Subscriber's Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____ - _____

Birthdate: Month _____ Day _____ Year _____ Social Security Number: _____ - _____ - _____

Relationship to Patient: _____

Employer: _____ Employer Phone: (____) ____ - _____

Secondary Insurance Co.: _____

Address: _____

Policy (ID) Number: _____ Group Number: _____

Subscriber's Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____ - _____

Birthdate: Month ____ Day ____ Year ____ Social Security Number: ____ - ____ - ____

Relationship to Patient: _____

Employer: _____ Employer Phone: (____) ____ - _____

Our office will file a patient's secondary insurance one time. After 30 days if no response from the insurance company the patient will be billed the balance due.

EMERGENCY CONTACT

Contact Name: _____

Relationship: _____

Phone: (____) ____ - _____

PREFERRED LAB

Most insurance companies have contracts with specific labs.

What is your preferred lab? _____

In lieu of providing Dr. Chu's office with this information I hereby authorize and consent for the office of Dr. Chu to send any and all of my lab work to the laboratory of their choice. I understand and agree that regardless of my insurance status I am ultimately responsible for any and all charges incurred with this laboratory.

AUTHORIZATION

I hereby authorize and consent for treatment from Thomas P. Chu, M.D., James Bridges, PA-C, and/or staff. I authorize Dr. Chu to furnish information to insurance carriers concerning this treatment and I hereby assign to the Doctor all insurance benefits otherwise payable to me but not to exceed the charges shown. I understand and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered. I have read both pages of the form and certify this information is true and correct to the best of my knowledge. I agree to pay a \$15.00 service charge if my check is returned for any reason. I also understand that I am responsible for reasonable collection costs and/or attorney fees incurred for collection of this account.

I agree to present my current insurance card at EACH visit and understand that my copay is due at the time of service. I understand that procedures not covered by insurance are due at the time of service. If we are not a contracted provider for your insurance company we will not file your insurance, but we will provide you with a paid receipt for you reimbursement.

Signature: _____

Date: _____