

PLYMOUTH FAMILY PHYSICIANS

DATE _____

DOCTOR BEING SEEN: **DR. ARENBERG**

DR. SCHROEDER

NAME, _____ M F BIRTHDATE _____ AGE _____
FIRST MIDDLE INITIAL LAST

SOCIAL SECURITY NUMBER _____ - _____ - _____ MARRIED SINGLE WIDOW DIVORCED

STREET _____ CITY _____ STATE _____ ZIP _____

PH. NUMBER _____ EMPLOYER _____ SPOUSE NAME _____

SPOUSES D.O.B. _____ SPOUSES SS # _____ SPOUSES EMPLOYER _____

NAME AND ADDRESS OF NEAREST LIVING RELATIVE _____

BILLING INFORMATION

PERSON RESPONSIBLE FOR BILL, IF DIFFERENT FROM ABOVE _____ PH. # _____

STREET _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE

PLACE OF EMPLOYMENT _____

INS. COMPANY _____

ADDRESS _____

GRP # _____ I.D. # _____

WHOSE INSURANCE _____

RELATIONSHIP TO PATIENT _____

FAMILY MEMBERS COVERED BY THIS POLICY _____

SECONDARY INSURANCE

PLACE OF EMPLOYMENT _____

INS. COMPANY _____

ADDRESS _____

GRP # _____ I.D. # _____

WHOSE INSURANCE _____

RELATIONSHIP TO PATIENT _____

FAMILY MEMBERS COVERED BY THIS POLICY _____

I, the undersigned, have insurance coverage with the aforementioned insurance company, and assign directly to Plymouth Family Physicians all medical benefits for services rendered. I understand that I am financially responsible for all charges whether or not, paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions. This authorization is in effect until I choose to revoke it in writing.

Signature: _____

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made to Plymouth Family Physicians for any services furnished me by that provider. I authorize any holder of medical information about me to release it to the Health Care Financing Administration and its agents any information about me to release needed to determine these benefits payable for related services. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or the agency shown. This authorization is in effect until I choose to revoke it in writing.

Signature _____

