PLYMOUTH FAMILY PHYSICIANS

DATE _____ DOCTOR BEING SEEN: DR. ARENBERG DR SCHROEDER

NAME _____ M F BIRTHDATE _____AGE ____
FIRST MI LAST

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

STREET _____ CITY _____ STATE _____ ZIP _____

PH. NUMBER: HOME#_____ WORK# _____ CELL#_____

EMAIL _____ EMPLOYER _____

SPOUSE'S NAME _____ SPOUSE'S D.O.B. _____

SPOUSE'S SS# _____-____-_____ SPOUSE'S EMPLOYER_____

……...

BILLING INFORMATION

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

STREET _____ CITY_____ STATE _____ ZIP _____

……

INSURANCE INFORMATION

PRIMARY INSURANCE
PLACE OF EMPLOYMENT _____
INSURANCE COMPANY _____
ADDRESS _____
GROUP # _____ I.D.# _____
WHOSE INSURANCE _____ DOB _____
RELATIONSHIP TO PATIENT _____
FAMILY MEMBERS COVERED BY THIS POLICY _____

SECONDARY INSURANCE
PLACE OF EMPLOYMENT _____
INSURANCE COMPANY _____
ADDRESS _____
GROUP # _____ I.D.# _____
WHOSE INSURANCE _____ D.O.B _____
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 my insurance submissions. This authorization is in effect until I choose to revoke it in writing.

SIGNATURE _____ DATE _____

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 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 _____ DATE _____