

What is the reason for your visit today? _____

PATIENT INFORMATION

Date of Visit _____
 Social Security # _____
 Patient Name _____

 Address _____
 City _____
 State _____ Zip _____
 Sex ___ M ___ F Age _____ Birthdate _____
 Marital Status _____
 Occupation _____
 Patient Employer _____
 Employer Address _____
 Employer Phone Number _____
 Spouse's Name _____
 Birthdate _____ SS# _____
 Spouses Employer _____
 Whom may we thank for referring you?

INSURANCE INFORMATION

Who is Responsible for this account?

 Subscriber's Name _____
 Relationship to Patient _____
 Birthdate _____ SS# _____
 Insurance Co. _____
 Insurance ID# _____ Group # _____
 Is the patient covered by additional insurance? ___ Yes ___ No
 Subscriber's Name _____
 Birthdate _____ SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Insurance ID# _____ Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

and assign directly to Dr. Ron W. Pelton, M.D., PhD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Ron W. Pelton, M.D., PhD may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to either me or on my behalf to Dr. Ron W. Pelton, M.D., PhD for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature _____
 Beneficiary or Guardian _____
 Relationship to Beneficiary _____ Date _____

PHONE NUMBERS

Home _____ Cell _____
 Best time and place to reach you _____
 Email _____
In case of Emergency, contact
 Name _____
 Relationship _____
 Home Phone _____
 Other Phone _____

FAMILY HISTORY

Are there any diseases or conditions that run in your family? Please List _____

	Age	Medical Conditions	If deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____
Children	_____	_____	_____

