RHEUMATOLOGY CONSULTANTS

PATIENT NAME

LAST_____ HOME PHONE_____

FIRST_____ WORK PHONE_____

MIDDLE_____ DATE OF BIRTH_____

STREET_____ SOCIAL SECURITY #_____

CITY_____ STATE_____ MARITAL STATUS_____

ZIP CODE_____ REFERRING MD_____

SEX: MALE FEMALE PRIMARY MD_____

EMPLOYER_____ SPOUSE_____

SPOUSE EMPLOYER_____

IN EMERGENCY CONTACT_____

PHONE NUMBER_____

PRIMARY INSURANCE COMPANY_____

NAME OF INSURED_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

RELATIONSHIP TO PATIENT_____

GROUP #_____ ID NUMBER_____

SECONDARY INSURANCE COMPANY_____

NAME OF INSURED_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

RELATIONSHIP TO PATIENT_____

GROUP #_____ ID NUMBER_____

All charges are due at the time of service. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of Insurance coverage. Before leaving our office you will be given a completed insurance form ready to submit to your insurance company. If we file your claim electronically, you will be given an itemized receipt.

I hereby authorize Rheumatology Consultants to furnish information to my insurance carriers concerning my illness and treatments. I understand I am responsible for all fees.

DATE_____ SIGNATURE_____

DATE_____ SIGNATURE_____