Patient Demographics/Insurance Authorization

Patient's Name | Male Female Gender (circle one) | Today's Date

Street Address | Apt. #

City | State | ZIP Code | Date of Birth | Age

Social Security # of Patient | Patient's or Guarantor's email address

Home Phone | Cell Phone | Work Phone

Emergency Contact Person | Relationship to Patient | Contact #

Employer's Name | Address | Phone #

Insurance Company Name | Policy # | Group #

If HMO, Name of Primary Care Physician (PCP)

Is the Patient the Policy Holder? (circle one) Yes No If no, complete the next 3 lines

Name of Insured | Relationship to Patient

Address of Insured (if not the same as above)

Social Security # of Insured | Date of Birth of Insured

Secondary Insurance Company (if any) | Policy # | Group #

Person Responsible for Payment (Guarantor, if other than patient) | Date of Birth | Social Security #

Guarantor's Address | Phone #

Guarantor's Employer | Work Phone #

I authorize release of medical information to Medicare or other insurance companies pertaining to my history, services rendered or treatment given to me or my dependents for purposes of claims review. I request that Medicare or other insurance companies make payments on my behalf directly to Dr. Spingarn. I am responsible for paying copayments at the time of service, if required by my insurance. I acknowledge and accept final responsibility for payment of all charges. If I do not pay all charges, I understand that my account may be sent to a collection agency and that an additional charge of 30% of the unpaid amount will be added to the bill as a collection fee. I am aware that tests sent to an outside laboratory may result in additional charges billed to me by the lab.

Signature | Date