JIMMY L. GREGORY, DPM

PATIENT INFORMATION

Date_______________

Name____

Last First Middle Initial

Address____

Street Number Name Apartment #

City______________ State______________ County______________

Telephone: (H)__________________ Social Security #______________________

Date of Birth___________ Marital Status_________________ Sex______________

RESPONSIBLE PERSON(S) INFORMATION

Medical Record #_____________ Name______________________ Sex__________

Relationship______________ Telephone #__________ Date of Birth____________

Address____________________________ Social Security #_____________________

City______________ State_______________ County_________________

EMPLOYER/INSURANCE/PAYMENT SOURCE INFORMATION

Employer____________________________________ Telephone #______________

Address____________________ City________ State ____________ Zip___________

Insurance_________________ Policy#______________ Group#__________________

Claims Address________________________ Telephone#________________________

MEDICAID #_______________________ MEDICARE #______________________

Statement of Financial Responsibility:

OUR OFFICE POLICY REQUIRES PAYMENT IN FULL FOR ALL MEDICAL SERVICES RENDERED AT THE TIME OF VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH THE OFFICE MANAGER.

I, ________________________, hereby authorize payment of medical benefits directly to physician for benefits due me for services rendered. I further authorize the physician and/or supplier to release any information required to process my insurance. I understand that I am financially responsible for ALL NON-COVERED SERVICES.

Signature of responsible party:_______________________________Date:____________