

The Family Health Center

PATIENT INFORMATION

Name: _____ S.S#: _____
Address: _____ City/State/Zip: _____
Home Phone: (____)____-____ Other Contact #: (____)____-____ Date of Birth ____/____/____
Gender: Male / Female **Marital Status: Single / Married / Widowed / Divorced / Separated
Employer: _____ Employer Phone: (____)____-____
Employment Status: Full Time / Part Time / Retired

POLICY HOLDERS INFORMATION

Guarantor's Name: _____ Relationship to Patient: Self / Spouse / Parent / Other
Guarantor's S.S#: _____ Guarantor's Date of Birth: ____/____/____
Employer: _____ Employer Phone#: (____)____-____
Employer Address: _____ Status: Full Time / Part Time / Retired

PRIMARY INSURANCE INFORMATION

****Please Provide Copy of Card**

Insurance Company Name: _____ Phone: (____)____-____
Insurance Identification #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION (MEDICARE PATIENTS ONLY)

****Please Provide Copy of Card**

Policy Holders Name: _____ Relationship to Patient: Self / Spouse / Parent / Other
Insurance Company Name: _____ Phone: (____)____-____
Insurance Identification #: _____ Group #: _____

Please Note:

It is not the practice of this office to submit secondary insurance claims, except for Medicare cross over. Please retain today's walkout receipt (along with your Primary insurance's explanation of benefits) to mail to your secondary insurance, to get reimbursed any co-insurance or co-pay.

**I hereby authorize direct payment of surgical/medical benefits to Dr. Tomas Friedrich for services rendered by him-In person or under his supervision. I understand that I am financially responsible for any balance not covered by the insurance.

Patient Signature: _____ Date: ____/____/____

** I hereby authorize Dr. Tomas Friedrich to release any medical information that may be necessary for medical care or processing Insurance claims.

Patient Signature: _____ Date: ____/____/____

****Medicare Patients Only**

I certify that the information given by me in applying for payment is correct. I authorize the release of all records on request. I request the payment of authorized benefits be made on my behalf.

Patient Signature: _____ Date: ____/____/____

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