Peus, Birch, Kahmann, Gallivan & Romero

Patient's Name _____ Male _____ Female _____ Age_____.
First Middle Last

Address _____ Birth Date ___/___/___
Street

_____ Marital Status _____
City State Zip

Home Phone (____) _____ Social Security # _____-_____-_____

Drivers License # _____ Emergency Contact _____

Employer Name & Address _____

Work Phone # (____) _____ Occupation _____

Spouse/Parent (if minor) _____ Relationship _____

Address _____ Phone (____) _____

Reason for visit _____

Allergies to medication _____

Referred by _____ Family Physician _____

Previous x-rays taken : When _____ Where _____

If injury or accident: Date ____/____/____ How it occurred _____

Attorney _____
Name Address

Work Related? _____ **If YES, please fill out workers compensation information sheet**

Insurance Information

Company: _____

Address: _____

Phone (____) _____ Insured _____

Please be aware we may not be providers of your insurance. We are required to bill your services to your insurance, which will be reimbursed at a non-provider rate.
"I hereby authorize my insurance company to pay the proceeds of any benefits otherwise due to me directly to Peus, Birch, Kahmann, Gallivan & Romero. I authorize the release of any medical information necessary to process my claim and understand that I am responsible for all of the charges for all services rendered to me or any member of my family."

Signed _____ Date _____

Medicare Patients

Medicare # _____ Primary Insurance? Yes _____No _____.

Please allow us to make a Xerox of your Medicare card. We are required to submit claims with your name exactly as it appears on your card. We are not providers of Medicare, which means we do not accept assignment: however, we are required to bill your services to Medicare. Any remittance will be mailed directly to you, and you will receive a statement from us at the end of the month which will show when Medicare was billed.
"I request that payment of authorized benefits be made either to me or on my behalf to Peus, Birch, Kahmann, Gallivan & Romero for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Admin. Any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for all of the charges for all services rendered to me."

Signed _____ Date _____