Patient Information

account#___________

Name: ______________________ Marital Status: ______________
SSN# ______________________ Employment Status: Full Part Unemployed
DOB: ______________________ Employer: ______________________
Gender: Male Female **Referred by:** ______________________

Address: ______________________ **Home phone#** ______________
______________________ **Work Phone#** ______________
______________________ **Cell Phone#** ______________
Email address: ______________________
Emergency Contact Name: ______________________
Emergency Contact Phone# ______________________

Primary Care Physician: ______________________

Primary Insurance Company:
____
Policy# ______________________
Group# ______________________
Mail claims to address: ______________
____
Co-pay$ ________
Policy Holder Name: ______________
Address: ______________________
____
SSN# ______________________
DOB: ______________________
Gender: Male Female

Secondary Insurance Company:
____
Policy# ______________________
Group# ______________________
Mail claims to address: ______________
____
Co-pay$ ________
Policy Holder Name: ______________
Address: ______________________
____
SSN# ______________________
DOB: ______________________
Gender: Male Female

I hereby authorize my insurance benefits to Kevin M. Plaisance M.D., L.L.C.. I understand that I am financially responsible for any charges not covered by this assignment. I also hereby authorize the release of any information to the above listed insurance company or other third parties. I also authorize responsible third parties to pay directly to Kevin M. Plaisance M.D., L.L.C. any benefits due me for services rendered to me by the office of Kevin M. Plaisance M.D., L.L.C. I also understand that I am financially responsible for any unpaid balance due to Kevin M. Plaisance M.D.,L.L.C.

Patient Signature: ______________________ Date: ______________