SOUTHERN TIER ARTHRITIS & RHEUMATISM

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PATIENT INFORMATION:

NAME: _____

DOB: _____ _____ MALE _____ FEMALE

SOCIAL SECURITY #: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____

WORK PHONE: _____ CELL PHONE: _____

PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT: _____PHONE:_____

INSURANCE: _____REQUIRE A REFERRAL? ____

SUBSCRIBERS NAME: _____DOB:_____
(IF OTHER THAN YOURSELF)

I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSSARY TO SECURE THE PAYMENT OF BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY MY INSURANCE.

RESPONSIBLE PARTY SIGNATURE DATE