## PATIENT INFORMATION

Patient Name:_____
LAST FIRST MI

Date of Birth: _____/_____/_____ Age:_____ SS#:_____-_____-_____

## PRIMARY MEDICAL INSURANCE

**Primary Insurance Carrier:** _____

Policy#:_____ Group#:_____

Name of Primary Policyholder: _____ Date of Birth: ____ / ____ / ____

Policyholder SS#:_____-_____-_____

Relationship of Patient to Policyholder: ☐SELF ☐WIFE ☐HUSBAND ☐CHILD ☐OTHER

## SECONDARY INSURANCE (if applicable)

**Secondary Insurance Carrier:**_____

Policy#:_____ Group#:_____

Name of Primary Policyholder: _____ Date of Birth: ____ / ____ / ____

Policyholder SS#:_____-_____-_____

Relationship of Patient to Policyholder: ☐SELF ☐WIFE ☐HUSBAND ☐CHILD ☐OTHER

## VISION PLAN INSURANCE (if applicable)

**Vision Plan Insurance Carrier:**_____

Policy#:_____ Group#:_____

Name of Primary Policyholder: _____ Date of Birth: ____ / ____ / ____

Policyholder SS#:_____-_____-_____

Relationship of Patient to Policyholder: ☐SELF ☐WIFE ☐HUSBAND ☐CHILD ☐OTHER

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**Please Read:** I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I understand if I have insurance and have provided accurate and complete information regarding my insurance, my charges will be filed with my insurance carrier; however, the financial responsibility for services rendered to a patient ultimately rests with the patient or responsible party. I understand that my copay and/or any coinsurance monies are due at the time of service. If I do not have insurance or my charges are not to be filed with insurance, payment in full is due at the time of service. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me, I agree to pay all reasonable attorney's fees (33.33%) and any other court costs or costs of collection. I hereby authorize assignment and payment directly to Barry J. Edison, D.O., PC any major medical benefits due me for services provided by them.

X_____ _____

Signature of Responsible Party Date