

**WELCOME TO THE PRACTICE**



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\*\*\*PATIENT INSURANCE INFORMATION & RELEASE AUTHORIZATION\*\*\*  
(PLEASE PRINT CLEARLY)

Patient Name:	Phone: (570)
Address:	Social Security #:
Birth date:	Allergic to:  (*Including allergies to shellfish or IVP dye)
Referred by:	Are you a diabetic?      YES      NO
Medical Doctor:	Are you an asthmatic?      YES      NO
Emergency Contact Person:	Phone: (570)

<b>PRIMARY HEALTH INSURANCE</b>	<b>SECONDARY HEALTH INSURANCE</b>
Name:	Name:
Address:	Address:
ID#:	ID#:
Group:	Group:
Subscriber's Name:	Subscriber's Name:
Relationship:	Relationship:

I, the undersigned, hereby grant permission to release my medical information and authorize payment of benefits to: PREMIERE SURGICAL. I also understand that I am fully responsible for payment of DEDUCTIBLES AND CO-PAYMENT and any charges that are incurred and not covered by my insurance. MEDICARE PATIENTS: "I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made to: PREMIERE SURGICAL for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits and payment for related services".

SHOULD THIS ACCOUNT GO TO COLLECTIONS FOR NON-PAYMENT,  
THE PATIENT/GUARANTOR ACCEPTS RESPONSIBILITY FOR ALL COLLECTION FEES.

**Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_

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