PATIENT INFORMATION

Please print clearly

Full Name_____

Birth Date (MM/DD/YYYY)_____ Gender M F Age_____

Mailing Address_____

City/State/Zip_____

Phone Number_____ Cell Number_____

Email Address_____

Preferred method of contact: Home phone Cell phone Work phone E-mail

May we contact you via email or text? Y N

Insurance Information

Insurance Carrier_____ Policy Number_____

Insured's Name_____ Insured's Birth Date (MM/DD/YYYY)_____

Insured's Address_____

Relationship to Insured: Self Spouse Child

Primary Care Physician:_____ Phone_____

Authorization to release information

I hereby authorize Dr Scott Bockelmann to release any information concerning my physical condition, which may be deemed appropriate and necessary, to any Medicare/Insurance company and/or adjuster, medical provider, attorney or social worker in order to have processed any claim for reimbursement of charges incurred by me as a result of professional services rendered by Dr Scott Bockelmann.

_____ _____

Signature of Patient Date

Assignment of Benefits

I hereby assign benefits directly to Dr Scott Bockelmann for all professional services rendered. I hereby authorize payment to be made to Dr Scott Bockelmann for any sum I owe, or may owe in the future, to Dr Scott Bockelmann in connection with any professional services rendered to me.

_____ _____

Signature of Patient Date