

PERSONAL INFORMATION

NAME: _____ EMAIL ADDRESS: _____
Last First M.I. HOME PHONE: _____

Address: _____

SS#: _____ Date of Birth: _____ City State Zip
Marital Status: S M D W

Occupation: _____ EMPLOYER: _____

Employer's Address: _____ PHONE NO.: _____

SPOUSE/PARENT'S NAME: _____ PHONE NO.: _____

Occupation: _____ EMPLOYER: _____

Employer's Address: _____ PHONE NO.: _____

NAME AND PH# Of Someone Not Living With You To Contact In Case Of Emergency

PERSON RESPONSIBLE FOR BILL: SELF: _____ OTHER: _____

Address: _____ PHONE NO.: _____
City State Zip

**** INSURANCE INFORMATION ****

PAYMENT OF OUR FEES IS YOUR RESPONSIBILITY

PRIMARY: DATE OF BIRTH: _____ SS#: _____
NAME OF INSURED: _____
Address: _____

INSURANCE COMPANY: _____ City State Zip
Copy of Card Attached ___ Yes ___ No
Address: _____
City State Zip

I.D. NO.: _____

SECONDARY DATE OF BIRTH: _____ SS#: _____
NAME OF INSURED: _____
Address: _____

INSURANCE COMPANY: _____ City State Zip
Copy of Card Attached ___ Yes ___ No
Address: _____
City State Zip

I.D. NO.: _____

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN

I hereby authorize payment directly to Dr. Jason D. Meier of the surgical and/or medical benefits, otherwise payable to me, for their services. I also authorize Dr. Jason D. Meier to release any information acquired in the course of treatment for insurance purposes.

I UNDERSTAND THAT RESPONSIBILITY FOR PAYMENT LIES SOLELY WITH ME.

SIGNATURE (INSURED OR AUTHORIZED PERSON) _____ DATE: _____