

Date: _____

Patient Demographic Information

Name: _____ Social Security Number _____
Last, First Name MI

Address: _____ City, State, Zip: _____

Home Phone # (____) _____ Sex ___ M ___ F D.O.B. _____ Martial Status: _____

Parent/Guardian (If under 18) _____

Employer: _____ Occupation: _____

Business Address: _____ Work Phone # _____

Emergency Contact: _____ Phone # _____

PRIMARY / ADDITIONAL INSURANCE

Insurance Company: _____ Group # _____ Subscriber # _____

Insured _____ Date Of Birth: _____
Last Name First Name MI

Relationship to Patient: _____ Social Security # _____

Address (if different from patient's) _____

City, State, Zip: _____ Phone Number: (____) _____

Insured Employed By: _____

Business Address: _____

City, State, Zip: _____ Phone Number: (____) _____

Is the patient covered by an additional insurance? ___ Yes ___ No

Insurance Company: _____

Group # _____ Subscriber # _____

Insured: _____ Date Of Birth: _____

Relation to Patient: _____ Social Security # _____

Address (If different from Patient's) _____

City, State, Zip _____ Phone Number: (____) _____

Insured Employed by: _____ Business Address: _____

City, State, Zip: _____ Phone Number: (____) _____

ASSIGNMENT AND RELEASE

I, the undersigned, do hereby authorize Dr. _____ to release to (Insurance Company) _____
In addition, all medical information, of whatever nature, now in their possession or later required, from whatever source, which pertains or relates to my medical care. This authorization and consent is granted for the sole and limited purpose of facilitating the quality assurance and quality improvement activities conducted by the health plan. I understand and agree that by consenting to and granting this authorization, I am releasing those rights and claims of confidentiality and privilege concerning the information described which may otherwise exist, when used for the purpose described. I further understand and agree that I may withdraw my authorization and consent at any time by written notice of withdrawal to the health plan, provided however, that any such withdrawal will not affect any information disclosed prior to receipt by the health plan of the written notice of withdrawal.

Signature: _____

Date: _____

