PATIENT INFORMATION (PLEASE PRINT)

PATIENT'S NAME_____ **DATE**_____

DATE OF BIRTH_____**SOC. SEC.#**_____ **DRIVERS LIC#**_____

ADDRESS_____ **TEL #**_____
Number & street **city** **state** **zip**

CELL PHONE #_____

E-MAIL ADDRESS_____

PATIENTS/GUARANTOR'S EMPLOYER_____ **TEL #**_____

EMPLOYER ADDRESS_____
Number & street **city** **state** **zip**

EMERGENCY CONTACT:_____ **TEL#**_____

HOW WERE YOU REFERRED TO OUR OFFICE_____

INSURANCE INFORMATION (PLEASE LET US COPY YOUR INS. CARDS)

PRIMARY INSURANCE:

INS. CO. NAME_____

INSURED ID#_____

GROUP#_____

INSURED NAME_____

INS. CO. PHONE#_____

PATIENT'S RELATIONSHIP TO INSURED

SELF □ SPOUSE □ CHILD □ OTHER □

SECONDARY INSURANCE:

INS. CO. NAME_____

INSURED ID#_____

GROUP#_____

INSURED NAME_____

INS. CO. PHONE#_____

PATIENTS RELATIONSHIP TO INSURED

SELF □ SPOUSE □ CHILD □ OTHER □

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other plan to *KEITH S. FEDER, MD.* I hereby authorize/consent to treatment, by Keith S. Feder, MD and Associates. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I also understand that should legal action be necessary to collect any unpaid balance due for medical services rendered I will be held responsible for all attorneys' fees and other costs of collection to the full extent permitted by law. I hereby authorize said assignee to release information necessary to secure payment. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Signature of responsible party **date**