Welcome to the office of Dr. Jack Devore and Dr. Gina Litz

PATIENT INFORMATION:

Patient's name ______________________________ Sex M F

Date of Birth ____________ Age ______ Social Security Number ______________

Marital Status (circle one) Single Married Divorced Widowed Separated Other

Address: Street ______________________________

City ______________ State ______ Zip Code ____________

Home Phone (____)____________ Day/Work Phone (____)______________

Cell Phone (____)____________ Occupation ______________

Patient's Employer ______________________________

Spouse's name ______________________________

Spouse's DOB ______________ Social Security# ______________

Family Physician ______________________ Phone (____) ______________

Physician Address ______________________________

Whom may we thank for referring you to our office? ______________________

EMERGENCY CONTACT:

Name ______________________

Relationship ______________________

Address ______________________

____

Phone (____) ______________________

IF PT UNDER 18 - PERSON RESPONSIBLE FOR BILL

Name ______________________

Relationship ____________ DOB ________

Address ______________________

____

Phone (____)______________________

INSURANCE INFORMATION:

Primary______________________

Policy Holder's Name ______________________

Date of Birth ______________________

Secondary ______________________

Policy Holder's Name ______________________

Date of Birth ______________________

Insurance Authorization, Assignment and Responsibility:
I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Dr. Jack Devore on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim) my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. I agree to accept responsibility for payment in full for services rendered, in the event they are not covered by my third party payor (e.g. my private insurance company, health maintenance organization or Medicare carrier.)

Date: ____________ Signature: ______________________________

New registration form 090215