

Patient's Personal Information Marital Status: single married divorced widowed

Name: _____
Last name first name initial

Address: _____ City: _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security # _____ - _____ - _____ Date of Birth _____ Religion(optional) _____

How do you wish to be addressed? _____ Referred by: _____

Employer Name: _____ Occupation: _____

Spouse's Name: _____ Work #: _____

Policy Holder Information (person who carries insurance)

Policy Holders Name: _____ Date of Birth: _____

Relationship to patient: Self Spouse Other: _____ Social Security #: _____ - _____ - _____

Employer's Name: _____ Work #: _____

Primary Care Physician

Name: _____ Address: _____ Phone #: _____

Emergency Contact (In case of an emergency)

Name: _____ Phone: _____ Relationship _____

Insurance Information (copy of insurance card)

Primary Insurance: _____

Address: _____

ID Number: _____ Group #: _____ Copay: _____

Secondary Insurance: _____

Address: _____

ID Number: _____ Group#: _____ Copay: _____

I understand and acknowledge that my insurance coverage is a contract between me and my insurance company and that I am personally responsible for all medical expenses incurred during evaluation and treatment by Susan Peck, MD, PC. And her associates. I understand that as a courtesy my primary insurance will be billed however, it is my responsibility to follow up on delinquent claims. If I am a member of a PPO or an HMO I am required to make my co-pay and co-insurance payments in a timely fashion, and I am responsible for keeping my primary care physician referrals current. I authorize Susan Peck, MD, PC and/or representatives to release all necessary medical information to my insurance carrier for processing my claims. I assign all benefits from said claims to Susan Peck, MD, PC. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient or responsible party: _____ Date _____ Relationship _____