Patient Information – Please print

____
Last name First name Middle initial

____/____/____ ____-____-____ ____________________
Date of birth Social security number Email address

____
Mailing address City State Zip

____
Physical address City State Zip

____
Best phone number Alternate phone number

____
Referring doctor Address Phone number

____________________ ____________________
Occupation Partner's Occupation

____________________ ____________________
Partner's name & phone number Emergency contact & phone number

Insurance Information

Patients relation to insured: Self □ Partner □ Dependent □ Child □ Other □

Primary insurance: Name of insurance:________________________
Name of insured:________________________
Insured's date of birth:________________________
Insured's Social Security #:________________________
Policy number:________________________
Insurance company address:________________________
Insurance company phone #:________________________

Secondary insurance: Name of insurance:________________________
Name of insured:________________________
Insured's date of birth:________________________
Insured's Social Security #:________________________
Policy number:________________________
Insurance company address:________________________
Insurance company phone #:________________________

I authorize Dr. Minior to release to the Social Security Administration or Health Care Financing Administration or their intermediaries or carriers, or to the billing agent of this physician, any information needed for this claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signature: ________________________ Date: ________________

Assignment of benefits: I authorize payment of benefits directly to Victoria Minior, MD, PLLC for services rendered. I understand that I am financially responsible to the provider for charges not covered by my benefit plan.

Signature: ________________________ Date: ________________

I have received a copy of the privacy notice. Signature: ________________________