PATIENT/ INSURANCE INFORMATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle:_____

Gender: __M __F Ethnicity: White____Black____Hispanic____Other___SS#:_____

Birth Date:_____ __Age: _____ Height:_____Weight:_____Blood Pressure:_____/____

Home Address: _____ Apt: _____

City: _____ State: _____ Zip:_____

I will be seen by either Dr. Robert Bercier and/or Dr. Danielle Bercier

Home Phone: _____Cell Phone_____ Work Phone: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

SPOUSE/GUARDIAN OR EMERGENCY CONTACT (circle one)

Last Name: _____ First Name: _____ Middle:_____

Date Of Birth: _____ SS #: _____ Relation to Patient:_____

Home Phone: _____Cell Phone_____ Work Phone_____

Employer Name and Address: _____

INSURANCE INFORMATION

Insurance Name: _____ Contract number: _____

Insured Name: _____ SS#: _____ Date of Birth: _____

Employer: _____

Is this visit related to Workers Comp or a Liability case: _____ Yes _____ No

We need a copy of insurance card(s) for our records.

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the part who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

_____ _____

Signature of Patient or Guardian Date