

PATIENT INFORMATION - Please Print-

It is important that you complete this form in its entirety. Thank you for your assistance.

Today's Date: _____ Please circle- Male / Female

First Name _____ Last name _____ M.I. _____

Date of Birth _____ Social Security # _____

Home address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

May we contact you via phone? Yes ___ No ___ Signature _____

Can we contact you via email? Yes ___ No ___ Signature _____

Employer's Name _____ Position: _____

Primary Care Physician _____ Referring Physician _____

Pharmacy Preference & Location _____

Marital Status- Single ___ Married ___ Divorced ___ Widowed ___ Domestic Partner ___

Primary language _____

Race -check one- Caucasian ___ African American ___ Asian ___

Ethnicity -check one- Hispanic or Latino ___ Not Hispanic or Latino ___

Native Hawaiian /Pacific Islander ___ American Indian /Alaska Native ___

Undefined/ Unknown ___ Other _____

Emergency Contact Person: _____

Home Phone _____ Cell Phone _____ Relationship _____

Email address: _____

PRIMARY INSURANCE INFORMATION

****Please present current insurance card to receptionist****

Primary Insurance Company _____

Policy#: _____ Group#: _____

Policy Holder Name _____ Date of birth _____ SS# _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company _____

Policy#: _____ Group#: _____

Policy Holder Name _____ Date of birth _____ SS# _____

ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby assign all medical and/or surgical benefits, to which I am entitled to DIANE BAIRD M.D.,P.C.. This assignment remains in effect until revoked by me in writing. A facsimile or photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I consent to the release of information by DIANE BAIRD M.D.,P.C., and my health insurance and/or payor to DIANE BAIRD M.D.,P.C., and its employees/ representatives to facilitate peer review and of my treatment including utilization and quality management. I understand that DIANE BAIRD M.D.,P.C. will maintain the confidentiality of this information at all times. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that my medical insurance is a contract between myself and the insurance company and/ or my employer. DIANE BAIRD M.D.,P.C. is not party to said contract. I understand that I am responsible for legal and/or collection fees necessary to settle my account, should it become delinquent.

SIGNATURE X _____ DATE _____