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PATIENT INFORMATION

Name _____ Email _____

Marital Status (circle) S M D W Date of Birth _____ Age _____ Sex _____ SS # _____

Mailing Address _____ Home Phone () _____ - _____
Street
City State Zip Code Cell # () _____ - _____

Patient's Employer _____ Work phone: () _____ - _____

Occupation _____

Spouse/Parent _____ Spouse/Parent Phone # () _____ - _____

Primary Insurance Co. _____ Phone () _____ - _____

Address _____ Co-Pmt \$ _____

Subscriber Name: _____ ID # _____ Group # _____

Secondary Insurance Co. _____ Phone () _____ - _____

Address _____

Subscriber Name: _____ ID # _____ Group # _____

Responsible Party (Please circle) Self Spouse Father Mother Auto Other

Address _____

In Case of EMERGENCY:

Person to contact (not living with you) _____ Phone() _____ - _____

Worker's Comp/Auto Ins. _____ Phone () _____ - _____

Adjuster: _____ Claim# _____

Date of injury _____ How injury occurred _____

Reason for this visit: ___Cosmetic ___Injury ___Job related injury ___Auto Accident ___Other

Physician Referral: _____ Primary Care Physician: _____

Insurance Authorization (Please read and sign):

I hereby authorize GREGORY L. COMBS M.D., P.C. to furnish information to insurance and Medicare carriers concerning my illness and treatment and I hereby assign to Dr. Combs all benefit payments, basic and major medical services rendered to myself or to my dependents. I understand if I participate in a managed care plan that to receive benefits I must have a valid referral from my Primary Care Physician before being seen by Dr. Combs. If I am seeking care, and no valid referral has been issued, I am responsible for payment of charges related to my care. All collection costs and attorney fees are incurred by patient if not paid as agreed.

Signature _____ Date _____