

Eastpointe Internists, PC

Last Name, First, Middle Initial					
Address, City, State, Zip Code					
Telephone ()		Social Security #		Marital Status S M W D	
Spouse's Name	Patient's Birthdate	Age	Sex M / F	Driver's License #	
Patient's email address:					
Responsible Party (if different than above)		Address, City, State, Zip and Telephone			

EMPLOYMENT INFORMATION

PATIENT'S Employer:		Phone
Employer Address, City, State, Zip		Occupation
SPOUSE'S Employer		Phone
Employer Address, City, State, Zip		Occupation

INSURANCE INFORMATION : PRIMARY INSURANCE SECONDARY INSURANCE

Insurance Company Name		
Subscriber Name Subscriber Date of Birth		
Subscriber Group # Subscriber Contract # Subscriber Service Code #		
Subscriber Employer, Address & Phone #		

Who should we contact in case of an Emergency - OTHER than your home? Relationship:	Name & Address	Phone #
Who referred you to our office so we may thank them?	Name & Address	Phone #

Authorization to pay benefits to Provider, Release of Medical Information & Receipt of Notice of Privacy Policies & Practices

I hereby authorize payment directly to Eastpointe Internists, PC for any medical benefits otherwise payable to me for their services. I hereby authorize Eastpointe Internists, PC to release any medical information necessary for payment of my insurance claim. I understand I am responsible for payment of any services not covered by my insurance, all copays, deductibles, statement fees and no show appointment fees, if applicable. I authorize you to give reasonable and proper medical care as determined by today's standards. I acknowledge receipt of Eastpointe Internists, PC's Notice of Privacy Policies.

Patient Signature

Date