Eldersburg Arthritis, LLC

PLEASE FILL FORM OUT COMPLETELY AND PRINT CLEARLY.

Today's Date: _____
Patient Name: Last:_____First:_____Initial:_____
Street: _____
City: _____State: _____ Zip: _____
Home Phone: _____Work:_____Cell:_____
Date of Birth: _____SS#: _____ Sex: M F (circle one)
Marital Status: S M W D (circle one) Spouse (parent if minor) _____
Spouse/Parent address if different than above: _____
Spouse/Parent Home Phone: _____ Work:_____Cell:_____
Emergency Contact: _____ Emergency Contact Ph: _____

Family Physician Name: _____ Phone: _____
Family Physician Address: _____

Referring Physician (if different from Family Physician): _____
Referring Physician address: _____ Phone: _____

Is your illness/injury related to work, your job, a motor vehicle accident, or any other type of accident which may end up in court for which you will seek compensation from a third party?
Circle one and initial beside your answer. Yes No
If yes to the above question, please see the receptionist before filling out any further information.

BILLING AND INSURANCE INFORMATION (complete all that apply)

Primary Insurance Company Name: _____
Policyholder Name: _____Relationship to patient: _____
Policyholder Date of Birth: _____ Policyholder SS#: _____
Policyholder Employer: _____Work Phone: _____
Secondary Insurance Company Name: _____
Policyholder Name: _____Relationship to Patient: _____
Policyholder Date of Birth: _____SS#_____
Employer: _____ Work Phone: _____

I hereby authorize Eldersburg Arthritis, LLC to apply for benefits on my behalf for covered services for my insurance companies, and request payment be made directly to the above named provider. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent, (or in case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing. I agree to pay any outstanding balances within 30 (thirty) days of receipt.

Signature of Subscriber or Beneficiary: _____