PATIENT INFORMATION (PLEASE PRINT ALL INFORMATION)

Chart No. _____
Today's Date:_____
Last Name:_____
First Name:_____
Middle Name:_____
Street Address:_____
City:_____ STATE:_____
Zip Code:_____
E-Mail:_____
Home Phone:( )_____ Work Phone: ( )_____
Cell:( )_____ Fax No. ( )_____
Other:_____
Birth Date:_____ Age: _____ Marital Status: _____
Social Security No.:_____
Driver's License No.: _____ Employer Name: _____
Emergency Contact Person:_____ Relationship:_____
Home Phone:( )_____ Cell: ( ) _____
How do you plan to pay for services? (circle one): Insurance or Private Pay
Do you have more than one insurance?: If yes please inform receptionist.
Name of Primary Insurance:_____
Name of Policy Holder:_____
Relationship to Policy Holder (circle one): Self Spouse Child
Name of Policy Holder if not "Self":_____
Birth Date of Policy Holder if not "Self":_____
Social Security No. of Policy Holder if not "Self":_____
Employer Name of Policy Holder if not "Self": _____
Policy No.:_____Group No.:_____Co-Pay amount:____
Refered by: _____

I hereby consent to treatment by the physician(s) and/or associates of A. Bert Blackburn M.D.
I understand that I am responsible for any/all co-pays, deductibles, percentages or any other charges not covered by my insurance. I understand that payment is expected at the time of service including all Medicare charges. I understand that all patient balances greater than 30 days old will be subject to a finance charge of not less then 2% of the balance owed. I understand that all accounts greater than 90 days old may be turned over for collections with a licensed collection agency. I understand and give permission to be contacted directly or indirectly by telephone, letter, post-card or e-mail.

Signature:_____Date:_____