PATIENT INFORMATION

Patient Name_____ Social Security #_____
Last First MI
Local Address_____ Driver Lic.#_____

City, State, Zip_____

Mailing Address_____
(If Different From Above)
City, State, Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Date Of Birth_____ Age_____ Sex __F ____M Marital Status: M S W D

Referred by: Friend_____ Doctor_____ Ad_____ Yellow Pages_____ Mailing____ Other_____
Name Name

INSURANCE INFORMATION

Primary Insurance Company_____Subscriber Name_____

Policy #_____Group #_____Effective Date_____

Secondary Insurance Company_____Subscriber Name_____

Policy #_____Group #_____Effective Date_____

EMPLOYMENT INFORMATION

Employer Name_____Occupation_____

Employer Address_____Work Phone_____

RESPONSIBLE PARTY INFORMATION

(Insured Subscriber if other than patient and/or person financially responsible if patient is a minor)

Name_____Address_____

City, State, Zip_____

Date Of Birth_____ Social Security #_____ Driver Lic.#_____

Employer Address_____Work Phone_____

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

I give authorization for diagnostic examinations, medical and/or surgical treatment, and administration of local anesthesia, for _____ by Dr. Edward Gross.

Signature_____ Date_____
Parent/Guardian with Legal Custody

EMERGENCY CONTACT

Name Of Person _____Relationship to Patient_____ Phone _____

Name Of Family Doctor_____ Phone _____

FORM OF PAYMENT

____Insurance ____Cash ____Check Credit Card: ____Visa ____MC ____AmEx

ASSIGNMENT/AUTHORIZATIONS AND RELEASES

I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

I AUTHORIZE EDWARD A. GROSS, M.D., P.A. TO RELEASE INFORMATION CONCERNING MY CARE TO SECURE INSURANCE PAYMENT BENEFITS. I ASSIGN TO EDWARD A. GROSS, M.D., P.A. ALL PAYMENTS FOR MEDICAL/SURGICAL SERVICES RENDERED TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I AGREE THAT A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

I UNDERSTAND THAT 48 HOURS CANCELLATION NOTICE IS REQUIRED TO AVOID A POSSIBLE MISSED APPOINTMENT FEE.

PATIENT SIGNATURE_____ **DATE**_____