Breastfeeding Fixers Patient Information Form

Please print all information in the spaces provided. Be sure to complete and sign the statement on the back of this form.

NAME_____SEX: M OR F DATE OF BIRTH_____

STREET ADDRESS_____

CITY/STATE/ZIP_____

HOME PHONE#_____CELL PHONE#_____

SS#_____EMAIL ADDRESS_____

EMPLOYER_____WORK PHONE#_____

DRIVERS LICENSE#_____REFERRING DOCTOR_____

EMERGENCY CONTACT_____PHONE#_____

BILLING INFORMATION

PRIMARY INSURANCE_____

SUBSCRIBERS
NAME_____SS#_____

DATE OF BIRTH_____

ID#_____GROUP#_____
_____

SECONDARY
INSURANCE_____

SUBSCRIBERS
NAME_____SS#_____

DATE OF BIRTH_____

ID#_____GROUP#_____
_____

PERSONAL INFORMATION

REASON FOR INITIAL
VISIT_____

CURRENT
MEDICATIONS_____

DRUG
ALLERGIES_____

I hereby authorize payment of medical benefits billed to my insurance to James G. Murphy, The Breastfeeding Fixers. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. A $30.00 fee will be charged for any returned check.

I agree to pay all co-payments, coinsurance and deductibles at the time the services are rendered.

I will pay by (check one) Cash_____ Check_____

_____

_____

Signature of patient or guardian Date