DRS. SAUER AND LEIBENSPERGER FAMILY PRACTICE, P. C.

Please Print
PATIENT: This Section refers to PATIENT ONLY

Date: ____________________________________

Name:___________________________________

Street Address: ____________________________

City:______________State:____Zip:___________

Home Phone:(____)_________________________

Work Phone:(____)_________________________

Cell Phone:(____)__________________________

Social Security Number:____________________

Sex:____Age:____Birth Date:________________

Marital Status:___Single___Married___Widowed

___Separated ___ Divorced

Spouse's Name:_____________________________

May we call you at home with test results or message? Y N

May we leave messages on your answering machine? Y N

May we leave messages w/ someone in your household? Y N

IN CASE OF EMERGENCY: Must be Completed

Name, Address & Phone Number of Nearest Relative or Friend NOT living with you:

Name:_____________________________________

Address:___________________________________

____

Phone Number:(____)_________________________

Relationship to patient:_________________________

COMPLETE ONLY IF PATIENT IS A MINOR

Father's Name:______________________________

Social Security Number:______________________

Work Phone:________________________________

Mother's Name:______________________________

Social Security Number:______________________

Work Phone:________________________________

Child lives with:___Both Parents___Mother___Father

___Other:_______________________

May we call you at work? Y N

Who is financially responsible for child?_____________

Primary Insurance:

Insured's ID Number:(on card)_________________

Group Number:____________________________

Effective Date:_____________________________

Subscriber/Guarantor:______________________
_

Guarantor Date of Birth:_____________________

Guarantor Social Security No:_________________

Relationship to Patient___Self___Spouse___Parent___Other

Secondary Insurance:

Address:__________________________________
_

City:___________________State:_____Zip:______
_

Insured (Name on ID Card)____________________

Insured Date of Birth:_________________________

Relationship to Patient:___Self___Spouse___Parent___Other

Insured's ID Number:__________________________

Group Number:______________________________

Effective Date:_______________________________

PLEASE COMPLETE OTHER SIDE

MEDICARE PATIENTS ONLY:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR MEDIGAP BENEFITS BE MADE ON MY BEHALF TO: DRS. SAUER AND LEIBENSPERGER FAMILY PRACTICE, P.C. I AUTHORIZE ANY NECESSARY MEDICAL INFORMATION ABOUT ME BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND IT'S AGENTS, OR MEDIGAP INSURANCE TO PROCESS AND PAY A CLAIM.

SIGNATURE OF PATIENT: ________________________________ DATE:__________________________

COMMERCIAL /HMO INSURANCE PATIENTS ONLY:

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DRS. SAUER AND LEIBENSPERGER FAMILY PRACTICE, P.C. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE FOR NON-ASSIGNED CLAIMS, OR ANY CO-INSURANCE OR DEDUCTIBLE FOR ASSIGNED CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY UNPAID CLAIM RESULTING FROM NOT FOLLOWING PROPER PROCEDURES OF INSURANCE PLAN.

SIGNATURE OF PATIENT: ________________________________ DATE:__________________________

SELF-PAY PATIENTS ONLY

ANY PATIENT WHO IS SELF-PAY, PAYMENT IN FULL IS REQUIRED AT TIME OF VISIT.

SIGNATURE OF PATIENT: ________________________________ DATE:__________________________

AUTHORIZATION TO FAX RECORDS:

I AUTHORIZE FAX TRANSMISSION OF MY MEDICAL RECORDS TO OTHER PHYSICIAN OFFICES OR HOSPITAL AS THE NEED ARISES.

SIGNATURE OF PATIENT: ________________________________ DATE:__________________________