

Jeffrey Ryan Family Medicine, PLLC

NAME _____ DATE OF BIRTH _____ MARITAL STATUS _____
 ADDRESS _____ AGE _____ GENDER Male Female
 CITY _____ STATE _____ ZIP _____ PHONE (H) _____ (W) _____
 NEXT OF KIN _____ SOCIAL SECURITY # _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____ EMPLOYER _____
 RELATIONSHIP _____ EMPLOYER'S ADDRESS _____
 PHONE (H) _____ (W) _____ CITY _____ STATE _____ ZIP _____

WHO IS RESPONSIBLE FOR THIS BILL? PATIENT OTHER _____

NAME _____ RELATIONSHIP TO YOU _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 EMPLOYER _____ SOCIAL SECURITY # _____

ARE YOU COVERED BY INSURANCE? YES NO

MEDICARE # _____	Other:
MEDICAID # _____	1. _____ ID # _____
NO FAULT (Ask for form) _____	Group # _____ Who insured: _____
_____	Address to send claim to: _____
_____	_____
_____	2. _____ ID # _____
_____	Group # _____ Who insured: _____
_____	Address to send claim to: _____
_____	_____

COMPENSATION CASE? Yes No If Yes, Date of Accident _____
 Name of Compensation Insurance Carrier _____
 Address _____

LEGAL CASE? Yes No If Yes, Name of Attorney _____
 Address _____

WHAT MEDICAL PROBLEM BRINGS YOU HERE? _____
 Date of Injury/Illness _____
 Describe symptoms and/or how injury occurred: _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I also authorize the physician to release any information required.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

Signed _____ Date _____

REFERRING DOCTOR:
 NAME _____
 ID# _____
 ADDRESS _____

Do you want your doctor to receive a copy of this report? Yes No