DANIEL S. ARICK, M.D., F.A.C.S.

PATIENT INFORMATION

PATIENT'S NAME:_____ SEX: ☐Male ☐Female DATE OF BIRTH:___/___/___
(Last) (First)

ADDRESS:_____ Apt.:_____ CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE: ( )_____-_____ CELL PHONE: ( )_____-_____ ☐ MARRIED - ☐ SINGLE

EMPLOYER:_____ _____ _____OCCUPATION:_____BUSINESS PHONE: ( )____-____

REFERRED BY

☐ Physician:_____

Address:_____ Phone: ( )_____-_____

☐ Friend/Relative
☐ Internet
☐ Other_____

EMERGENCY CONTACT

In case of emergency notify:_____ Phone: ( ) _____-_____

PRIMARY INSURANCE

INSURANCE COMPANY NAME:_____RELATIONSHIP TO PATIENT:_____

ADDRESS: (If different from above)_____ Date of Birth:____/____/____

POLICY ID #:_____ Group #: _____ CATEGORY #:_____

SECONDARY INSURANCE

INSURANCE COMPANY NAME:_____RELATIONSHIP TO PATIENT:_____

ADDRESS: (If different from above)_____ Date of Birth:____/____/____

POLICY ID #:_____ Group #: _____ CATEGORY #:_____

RELEASE

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.
I authorize release of information to all of my Insurance Companies.
I understand that I am responsible for my bill.
I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.

_____ _____
Patient's or Guardian Signature Date