

ALLERGIES: _____

PATIENT NAME: _____ DOB: _____ AGE _____

WHERE DID YOU HEAR ABOUT OUR OFFICE: _____

LOCAL ADDRESS: _____

HOME PHONE .() _____ CELL .() _____ WORK #.() _____

OUT OF TOWN ADDRESS: _____ OUT OF TOWN PHONE #() _____

MARITAL STATUS ___S___M___W___D___SEP___ SPOUSE NAME _____

SOCIAL SECURITY # _____ . STILL WORKING? Yes ___ No___ STUDENT? Yes___ No___

EMPLOYER _____

EMPLOYER'S ADDRESS: _____ PHONE NO. () _____
Street City State Zip

EMAIL: _____ @ _____

IN CASE OF EMERGENCY CONTACT: _____ **PHONE # ()** _____ **RELATIONSHIP** _____

PERSON RESPONSIBLE FOR PAYMENT, IF NOT YOURSELF? _____

THEIR ADDRESS: _____ THEIR PHONE: _____

PRIMARY CARE DR: _____ Referred by: _____ ?

PHARMACY NAME AND PH # _____ () _____

MEDICARE PATIENTS

Have you met your Medicare yearly deductible? ___Yes___No

Have you recently joined an HMO? If yes, **which?** _____

Are you covered by a HMO/PPO which makes Medicare your secondary insurance? ___Yes___No
If so, what is the Primary Insurance Name _____

Medicare ID # _____ **Secondary Insurer/ID#** _____

(Medicare patients are responsible for their yearly deductible and 100% of the allowable Medicare Fee. Medicare pays 80% of this fee. You, or co-insurer if you have one, are responsible for the full 20% Medicare does not pay.

I certify that the information given by me in applying for payment under Title VII of the Social Security Act is correct. Whether on Medicare or not, I authorize any holder of medical or other information about me to release to any referring physician and/or consultants as needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Sandy Martin M.D. J.D. P.A.

SIGN: PATIENT SIGNATURE (LEGAL GUARDIAN)

DATE