Account # _____ Birnkrant

PATIENT INFORMATION

***HIPPA Compliance mandates that patient information be updated each year.**
We will need to copy your driver's license and insurance cards. Please have these available.

First Name: _____ Last Name: _____

Address: Street _____
City: _____ State: _____ Zip: _____

Home # ( ) _____ Work # ( ) _____ Cell # ( ) _____

Date of Birth: _____ SS# _____ Email _____
Marital Status: _____ Name of Employer/School: _____

PRIMARY INSURANCE SUBSCRIBER INFORMATION

Subscriber's First name: _____ Subscriber's Last name: _____

Subscriber's Address: Street _____
City: _____ State: _____ Zip: _____

Home #: ( ) _____ Work #: ( ) _____ Date of Birth: _____

Social Security number: _____Relationship to patient: _____

Name of Primary Insurance: _____ Address to send Insurance forms: _____
_____

Effective date of this policy: _____ ID Number: _____Group # _____

Do you have any secondary insurance? _____ Name of ins. _____

Who referred you to this office? _____
Do you have any allergies to medications? **No Yes** (If yes, please list_____

PATIENT'S AUTHORIZATION

I hereby authorize Bruce G. Bonn, M.D., Sara L. Imershein, M.D., and Alan B. Birnkrant, M.D. to apply for benefits on my behalf for covered services and to furnish any necessary medical information to my insurance carrier which may pertain to my illness and/or for treatment received. Furthermore, I authorize payment of any benefits to be made directly to Bruce G. Bonn, M.D., Sara L. Imershein, M.D., or Alan B. Birnkrant, M.D. unless otherwise indicated.

I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance carrier at any time in writing.

Unfortunately, insurance companies will not guarantee benefits. Actual benefits will only be determined once a claim is received and reviewed. **I UNDERSTAND THAT I AM COMPLETELY RESPONSIBLE TO PAY ALL CHARGES IN FULL IF MY INSURANCE COMPANY DENIES BENEFITS OR DOES NOT PAY FOR CHARGES SUBMITTED.**

Date: _____ Signature: _____