

Name: _____ Date/Birth: _____ SEX: M – F _____

Address: _____ SS# _____ Age: _____

Marital
Status: _____

(Town) _____ (State) _____ (Zip) **** Referred by:** _____

Drivers License# _____ Cell Phone # () _____

Home Phone # () _____ Primary Ins.: _____

Occupation: _____ Address: _____

Employer: _____ ID # _____

Address: _____ Secondary Ins.: _____

ID # _____

(Town) _____ (State) _____ (Zip) **** Primary** _____

Work Phone # () _____ **Physician's Name:** _____

Name/Phone Number Emergency Contact. **** Primary** _____

() _____ **Physician Phone No.:** () _____

PERSON RESPON. FOR BILLING–SELF/SPOUSE/PARENT/GUARDIAN: (CIRCLE ONE)

Name: _____ Employer: _____

SS# _____ Insured D/O/B: _____

Address: _____ Employer: _____

Address: _____ Employer: _____

(Town) _____ (State) _____ (Zip) _____

IF AUTO/WORKERS COMP. INJURY, PLEASE COMPLETE THE FOLLOWING:

Insured's Name: _____ Date/Accident: _____

Ins. Company: _____ Policy# _____

Address: _____ Claim # _____

First day out of work: _____ Workers Comp.# _____

Representative: _____ Phone # () _____

I hereby authorize and request Paul Yerys, M.D./Jeffrey Meyer, M.D., Peter Lesniewski, M.D. to perform all necessary medical care, x-rays and other professional services on behalf of the above named patient. I agree to pay for all such services when statement is rendered, and I understand that I am personally responsible to pay same. I hereby authorize payment directly to the doctors for surgical and/or medical benefits if applicable. I hereby authorize a photocopy of this to be as valid as the original. All charges shall be fixed by you at regular rates. I further acknowledge that in the event my account remains past due and is referred to an outside collection agency, I agree, to authorize said entities to communicate with my insurance company regarding my past due account and further authorize said entities to obtain and/review my credit report.

Signature: _____ Date: _____

(Info #1)