INSURANCE INFORMATION

Date ________________

Patient's Name____________________________________ Birthdate__________________ Age_________

Address____ Soc Sec #________________________________

City________________State______ Zip______ Home Phone#___________________________________

Occupation_______________________________________ Work Phone#_____________________________
(if minor parent's work#)

Employer/School____

Address____

City_______________________ State___________ Zip____________________________________

Nearest Relative(not living with you)_______________________ Phone#________________________

Address:_______________________________ State__________________ Zip______________________

Primary Insurance_________________________________Policy/ID#_______________________________

Policy Holder_____________________________________Relation to Patient______________________

Policy Holder Soc Sec #__________________________Policy Holder Date of Birth______________

Policy Holder's employer____

Employer's address_______________________________City___________State_______Zip___________

Secondary Insurance_______________________________Policy/ID#______________________________
(if applicable)

Policy Holder____________________________________ Relation to Patient_____________________

Policy Holder's Soc Sec#_________________________ Policy Holder's Date of Birth___________

I hereby assign all medical and surgical benefits to which I am entitled to Gary J. Drillings, MD, PA. I understand that I am financially responsible for all charges whether or not they are covered by said insurance. In the event of delinquent account balances, I am fully responsible for all charges related to collection, including collection fees, finance charges and legal fees.

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Signature