PATIENT INFORMATION

NAME: ______________________________ **DATE OF BIRTH:** ____/____/____ **AGE:**________
(LAST) (FIRST) (MI)

ADDRESS: ______________________________
(STREET) (APT#) (CITY) (STATE) (ZIP)

HOME NUMBER: ( ) ______________ **WORK:** ( )________________ **CELL:** ( ) ______________________

E-MAIL ADDRESS: ______________________ **GENDER:** M F **STATUS:** S M D SEP W

SOCIAL SECURITY NUMBER: ________________ **DRIVERS LICENSE NUMBER:** ________________

EMERGENCY CONTACT: ________________ **RELATION:** __________ **PHONE NUMBER:** ( )__________

EMERGENCY CONTACT ADDRESS: ______________________________
(STREET) (APT#) (CITY) (STATE) (ZIP)

REFERRING PHYSICIAN (*REQUIRED*): ______________________ ( )________________

ADDRESS: ______________________________
(STREET) (APT#) (CITY) (STATE) (ZIP)

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE NAME: ______________________________

SUBSCRIBER'S NAME: ______________________________

SUBSCRIBER'S DATE OF BIRTH: ______________________

SUBSCRIBER'S SS NUMBER: ______________________

SUBSCRIBER'S RELATIONSHIP TO PT: ______________________
(e.g., self, spouse, mother, father)

EMPLOYER NAME: ______________________________

EMPLOYER PHONE NUMBER: _( )______________________

SUBSCRIBER/POLICY #: ______________________________

GROUP NUMBER: ______________________________

INSURANCE CLAIM MAILING ADDRESS: ________________
____
(NOT HOME ADDRESS)

SECONDARY INSURANCE

INSURANCE NAME: ______________________________

SUBSCRIBER'S NAME: ______________________________

SUBSCRIBER'S DATE OF BIRTH: ______________________

SUBSCRIBER'S SS NUMBER: ______________________

SUBSCRIBER'S RELATIONSHIP TO PT: ______________________
(e.g., self, spouse, mother, father)

EMPLOYER NAME: ______________________________

(If patient is a minor or married, please list parent/guardian/spouse employer and address information.)

EMPLOYER PHONE NUMBER: _( )______________________

SUSCRIBER/POLICY#:______________________________

GROUP NUMBER:______________________________

INSURANCE CLAIM MAILING ADDRESS:________________
____
(NOT HOME ADDRESS)

PLEASE TURN OVER TO READ AND SIGN, THANK YOU.

Assignment, Release and Financial Agreement (Please Read Carefully Before Signing)

I authorize treatment of ____________________________ and agree to pay all fees for
(Patient's Name)
services and treatment provided by Dr. Jennifer Maw and/or her designated providers. I hereby authorize my insurance benefits to be paid directly to Dr. Maw for services provided, and I realize that I am financially responsible for any services not covered by my insurance company. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I understand that my insurance company may deny payment for any reason including but not limited to the following: services not authorized by primary care provider, services not authorized /covered by my insurance company. Any claims paid to Dr. Maw by the insurance after full payment by the patient will be refunded. I realize that Medicare does not cover durable medical goods and that our office will not process durable medical goods through insurance companies.

I understand that there will be a charge for any missed appointment(s) not cancelled within 48 hours of the appointment and agree to pay for these services.

Dr. Maw is also pleased to offer patients professional services by electronic means (telephone or fax) and completion of work related forms or school forms etc. These services are subject to a minimum $25.00 charge and are otherwise prorated at an hourly charge of $400.00/hour. You will be notified prior to a service being rendered if a charge of more than $50.00 is anticipated. These charges do not apply to postoperative patients for 90 days post surgery, but otherwise are the responsibility of the patient. Calling (408) 540-5400 or faxing to (408) 540-5419 may access these services.

I acknowledge that failure to meet my financial obligations may result in referral of my account to a collection agency.

PATIENT SIGNATURE: ___________________________DATE:________
(Parent or guardian if patient a minor)

For your convenience, you may use Visa or MasterCard to settle your account.