Clear Form

Patient Profile

Doctor: Michael J McCormick, MD

PATIENT INFORMATION

Name: _____
Address: _____
_____
City, State: _____
Phone: _____ ☐Home ☐Work ☐Other
Phone: _____ ☐Home ☐Work ☐Other

Patient ID #: _____
Sex: ☐M ☐F
Date of Birth: _____
Social Security #: _____
Marital Status: ☐Married ☐Single ☐Divorced
Referring Physician: _____
Primary Physician: _____

PATIENT EMPLOYMENT

☐Employed ☐Retired ☐Unemployed ☐Other
Phone: _____
Employer: _____

CONTACTS

_____
_____
_____

GUARANTOR

☐Same as Patient
Name: _____
Address: _____
_____
City, State: _____

EMPLOYMENT

Employer: _____
Phone: _____
Phone: _____
Social Security #: _____
Date of Birth: _____

PRIMARY INSURANCE

☐Same as Patient ☐Same as Guarantor ☐Other
Insured Party: _____
Insured's Phone: _____
Company: _____

Relationship to Patient: _____
Social Security #: _____
Insured ID #: _____
Policy Group: _____
Date of Birth: _____

SECONDARY INSURANCE

☐Same as Patient ☐Same as Guarantor ☐Other
Insured Party: _____
Insured's Phone: _____
Company: _____

Relationship to Patient: _____
Social Security #: _____
Insured ID #: _____
Policy Group: _____
Date of Birth: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
(Name of Insurance Company)
and assign directly to Dr. Michael J. McCormick all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian:_____ Date: _____

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