

Patient Profile

Doctor: Michael J McCormick, MD

PATIENT INFORMATION

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

PATIENT EMPLOYMENT

Employed Retired Unemployed Other
Phone: _____
Employer: _____

GUARANTOR

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

PRIMARY INSURANCE

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

SECONDARY INSURANCE

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

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

CONTACTS

EMPLOYMENT

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

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

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: _____