J. Chris Beckman, M.D., PLLC

Today's Date: ____________________ How did you hear about our office? _________________________

PERSONAL INFORMATION:

NAME: ____
FIRST MIDDLE LAST

____
STREET ADDRESS CITY STATE/ZIP

(______) ____________________
HOME TELEPHONE

(______) ___________________________
CELL PHONE

____
DATE OF BIRTH

____
SOCIAL SECURITY NUMBER

____
EMAIL ADDRESS

(______) __________________________
WORK NUMBER

____
SPOUSE'S NAME

____
SPOUSE'S DATE OF BIRTH

____
SPOUSE'S EMPLOYER

(______) __________________________
SPOUSE'S WORK NUMBER

Where do you prefer to receive calls? _____ Home____ Work ____ Mobile

May we leave information on your answering machine or voice mail? _____ Yes ____ No

With whom may we share your health information? ____

Pharmacy name: ______________________________ Pharmacy phone # _____________________

In the event of an emergency please contact:

Name: __________________________________ Relationship: _________________
Home Phone: ____________________ Work Phone: _________________

B**ILLING INFORMATION (Who will pay for services not covered by insurance?)**
Name ______________________________________ Relationship to Patient ______________
Address ____
Date of Birth _________________________ Social Security # _________________________
Work Number _________________________ Home Number __________________________

INSURANCE INFORMATION (Please provide insurance card for us to copy)

PRIMARY INS CO ______________________
ID # _________________ Group # __________
Insured's Name ________________________
Insured's DOB ____________
Relationship to Patient SELF SPOUSE CHILD
Employer _____________________________
Insured's Social Sec # ___________________

SECONDARY INS CO _______________________
ID # ____________________ Group # __________
Insured's Name _____________________________
Insured's DOB ________________
Relationship to Patient: SELF SPOUSE CHILD
Employer __________________________________
Insured's Social Sec # _______________________

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to J. Chris Beckman, M.D., PLLC. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.

____ ____________________
Patient's Signature (Parent's signature if under 18) Date