

Last Name: _____ First Name: _____ MI: _____

Sex: _____ Date of Birth: _____ Social Security# _____

Address: _____

City: _____ State: _____ zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work #: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Who Referred You to This Office? _____

Family Doctor in Different? _____

Primary Insurance Name: _____

Id#: _____ Groups#: _____

Insured's Name: _____ Social Security #: _____ DOB: _____

Secondary Insurance Name: _____

Id#: _____ Groups#: _____

Insured's Name: _____ Social Security #: _____ DOB: _____

ASSIGNMENT OF BENEFITS TO PROVIDER:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CLAIMS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES RENDERED UNLESS ARRANGEMENTS ARE MADE IN ADVANCE. PLEASE READ AND SIGN THE FOLLOWING AUTHORIZATION AND ASSIGNMENT.

I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIMS PURPOSES AND IN EFFORT TO ASSURE PAYMENT OF MY BILL. MY SIGNATURE INDICATES THAT I HAVE READ ALL OF THE ABOVE AND HEREBY GRANT INSURANCE COMPANIES REQUEST FOR DOCUMENTS ALSO HEREBY ASSIGN TO CHRISTOPHER JORDAN, MD, LLC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.

PATIENT / GUARANTOR SIGNATURE: _____ Date: _____

Office Use Only

What are we seeing the patient for? _____

How did it happen? _____

Insurance Effective Date: _____ 2nd Effective Date: _____ Spoke With: _____

Copay: _____ Deductible: _____ DedMet: _____ CoInsurance: _____

Precert: MRI _____ Out pat. Surgery: _____ In pat Surgery: _____

APPT DATE: _____ APPT TIME: _____