Eldersburg Arthritis, LLC

PLEASE FILL FORM OUT COMPLETELY AND PRINT CLEARLY

Today's Date: _____
Patient Name: Last: _____ First: _____ Initial: _____
Street: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____
Date of Birth: _____ SS#: _____ Sex: M F (circle one)
Marital Status: S M W D (circle one) Spouse (parent if minor): _____
Emergency Contact: _____ Emergency Contact Phone: _____
Emergency Contact Relationship To Patient: _____
Spouse/Parent address if different than above: _____
Spouse/Parent Home Phone: _____ Work: _____ Cell: _____

Family Physician Name: _____ Phone: _____
Family Physician Address: _____
Referring Physician (if different from Family Physician): _____
Referring Physician Address: _____ Phone: _____

Is your illness/injury related to work, your job, a motor vehicle accident, or any other type of accident which may end up in court for which you will seek compensation from a third party?
Circle one and initial beside your answer. Yes No Initial: _____
If yes to the above question, please see the receptionist before filling out any further information.

BILLING AND INSURANCE INFORMATION (complete all that apply)

Primary Insurance: _____ Policy #: _____ Group # _____
Policyholder Name: _____ Relationship to Patient: _____
Policyholder Date of Birth: _____ Policyholder SS#: _____
Employer: _____ Employer Phone: _____

Secondary Insurance: _____ Policy #: _____ ___ Group # _____
Policyholder Name: _____ Relationship to Patient: _____
Policyholder Date of Birth: _____ Policyholder SS#: _____
Employer: _____ Employer Phone: _____

I hereby authorize Eldersburg Arthritis, LLC to apply for benefits on my behalf for covered services for my insurance companies, and request payment be made directly to the above-named provider. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of my necessary information, including medical information for this or any related claim to the above billing agent (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either myself or the above-named carrier at any time in writing. **I agree to pay any outstanding balances within 30 (thirty) days of receipt of the invoice.**

Signature of Subscriber or Beneficiary: _____