

PATIENT INFORMATION

Social Security Number	First Name	Middle Name	Last Name
Address			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
City	State	Zip	Home Phone
Email address	Family Doctor	Phone	Cell Phone
Employer	Work/Daytime Phone	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

PLEASE ALLOW RECEPTIONIST TO MAKE A COPY OF YOUR INSURANCE CARD.

INSURANCE INFORMATION

PRIMARY	Insurance Carrier		SECONDARY	Insurance Carrier	
	Name of Policy Holder			Name of Policy Holder	
	Insurance ID Number			Insurance ID Number	
	Address of Insurance Company			Address of Insurance Company	
	Phone # of Insurance Co.	Employer of Policyholder		Phone # of Insurance Co.	Employer of Policyholder
	Sex of Policy Holder <input type="checkbox"/> Male <input type="checkbox"/> Female DOB:			Sex of Policy Holder <input type="checkbox"/> Male <input type="checkbox"/> Female DOB:	
	Patient's Relationship to Policy Holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			Patient's Relationship to Policy Holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	

WHO MAY WE THANK FOR REFERRING YOU?

REFERRAL SOURCE

<input type="checkbox"/> Doctor	Name	Address	Phone No.
<input type="checkbox"/> Friend	Name	<input type="checkbox"/> Yellow Page Ad <input type="checkbox"/> Hospital <input type="checkbox"/> Internet <input type="checkbox"/> Other:	

IN CASE OF EMERGENCY PLEASE NOTIFY

Name					
Address					
City	State	Zip	Work Phone	Home Phone	Ext.

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PATIENT'S RESPONSIBILITY / MEDICAL RELEASE / ASSIGNMENT OF BENEFITS

I hereby acknowledge responsibility for any professional fees incurred and for obtaining any referral needed.
 I authorize release of medical information necessary to process my insurance claims.
 I request that payment of authorized benefits be made to Kurt Vernon MD PA for services furnished to me by them.
 Please provide your insurance card(s) at each visit or you may be asked to reschedule your appointment. **Please bring your medications or a current list of your medications to each office visit! Thank you.**

Signature	Relationship to Patient	Date
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