PATIENT DEMOGRAPHIC INFORMATION and AUTHORIZATIONS

John A. Schmidt, Jr., M.D. LLC

Please print and complete as fully as possible. Thank you!

PATIENT INFORMATION:

Name (L/F/M): _____ DOB: _____

Gender: M ◉ F ○ Marital Status: M ◉ S ○ W ○ D ○ SS# _____

Address: _____ __ Daytime Phone: _____

City: _____ State: _____ Zip: _____ Cell: _____

Email (home) _____ Email (work): _____

Spouse's Name _____ DOB _____

Pharmacy Name _____ Pharmacy Phone: _____

EMERGENCY CONTACT: _____ Phone: _____

INSURANCE INFORMATION:

Primary Insurance Information **Relationship to Patient: Self Spouse Parent Other**

Insurance Carrier: _____ Group Name _____ ID# _____

Insured Party Name: _____ DOB: _____

Employer: _____

Employer Address: _____

Secondary Insurance Information **Relationship to Patient: Self Spouse Parent Other**

Insurance Carrier: _____ Group Name _____ ID# _____

Insured Party Name: _____ DOB: _____

Employer: _____

Employer Address: _____

AUTHORIZATIONS:

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize payment of medical benefits to John A. Schmidt, Jr., M.D. LLC for any services furnished me by his Practice. I understand that I am financially responsible for any amount not covered by my contract. I also authorize the Practice to release to my insurance company information required for authorization of treatment and payment of claim benefits.

Signed: _____ Date: _____

MEDICARE LIFETIME SIGNATURE ON FILE:

I request that payment of authorized Medicare benefits be made on my behalf to John A. Schmidt, Jr., M.D. LLC for any services furnished me by his Practice. I authorize the Practice to release to the Health Care Financing Administration, its agents, and Medigap insurer any information needed to determine these benefits.

Signed: _____ Date: _____