

Patient Profile

Richard Nauheim, M.D.

Patient Information:

Sex: { }M { }F

Name: _____

Address: _____

City, State: _____

Phone: _____ { } Home { } Work { } Other

Phone: _____ { } Home { } Work { } Other

Patient Employment:

{ } Employed { } Retired { } Unemployed { } Other

Phone: _____

Employer: _____

Employer's Phone: _____

Guarantor:

{ } Same as Patient

Name: _____

Address: _____

City, State: _____

Primary Insurance:

{ } Same as Patient { } Same as Guarantor { } Other

Insured Party: _____

Insured Phone: _____

Company: _____

Secondary Insurance

{ } Same as Patient { } Same as Guarantor { } Other

Insured Party: _____

Insured Phone: _____

Company: _____

Patient ID#:

Date of Birth: _____

Social Security: _____

Marital Status: { } Married { } Single { } Divorced

Referring Physician: _____

Primary Physician: _____

Contacts:

Employment:

Employer: _____

Phone: _____

Phone: _____

Social Security: _____

Date of Birth: _____

Relationship to Primary _____

Insured/Guarantor:

Social Security: _____

Insured ID#: _____

Policy Number: _____

Insured Date of Birth _____

Relationship to Primary _____

Insured/Guarantor:

Social Security: _____

Insured ID#: _____

Policy Number: _____

Insured Date of Birth _____

I understand that I am receiving medical services from this office under the provisions of my insurance plan. I will be financially responsible for all deductibles, co-pays and co-insurances under the terms of my insurance contract.

If my insurance plan requires a valid referral to receive medical care, I understand that it is my responsibility to provide such referral. If my referral is determined to be invalid by my insurance carrier, I understand that I will be financially responsible for balances on my account. If my insurance plan is not accepted by this office or is of the 'indemnity' type, I understand that I am financially responsible for all balances remaining after payment of insurance benefits.

I hereby authorize and assign directly to Dr. Nauheim all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature: _____ Print: _____