PATIENT INFORMATION FORM

Date:_____

Name:_____

Soc. Sec. No.:_____Date of Birth:_____Age:_____

Address:_____

City:_____State:_____Zip Code:_____

Phone No.: (Home)_____(Cell)_____

Employed By:_____Work Phone:_____

Place of Work Address:_____

City:_____State:_____Zip Code:_____

Person Responsible For Bill:_____

Address:_____

City:_____State:_____Zip Code:_____

Insurance Information: Self Pay_____BCBS_____Medicare_____Medicare Advantage_____

Policy No.:_____

If BCBS Policy, Name on Policy:_____

Relationship to Patient:_____

Soc. Sec. No.:_____Date of Birth:_____

Emergency Information: (Person not living with patient to be reached in emergency)

Name:_____Phone:_____

Email: (Optional -- to receive a biweekly newsletter by Dr. Gruich and email access to physician)

_____

I authorize release of any medical information to my insurance company. I authorize payment of medical benefits to Dr. Charles Gruich, and I acknowledge that if my insurance company does not pay I will be responsible for the bill.

Signature:_____