

John B. Roach, Jr., D.O.

PATIENT INFORMATION

TODAY'S DATE _____

NAME _____

ADDRESS _____

CTY _____ STATE _____ ZIP _____

SS# _____ DATE OF BIRTH _____

MARITAL STATUS _____ HOME PHONE _____

CELL PHONE _____

EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

REFERRED BY _____

REASON FOR VISIT _____

EMAIL ADDRESS _____

EMERGENCY CONTACT _____

PHONE # FOR EMERGENCY CONTACT _____

PHARMACY _____ PHONE NUMBER _____

PLEASE PRESENT INSURANCE CARD AND DRIVERS LICENSE TO RECEPTIONIST

TO THE EXTENT NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT, I AUTHORIZE DISCLOSURE OF PORTIONS OF THE PATIENTS RECORD. I HEREBY ASSIGN ALL MEDICAL BENEFITS TO JOHN B. ROACH JR. D.O.. I ALSO AUTHORIZE THE RELEASE OF INFORMATION IN MY RECORDS TO THE INSURANCE COMPANY OR OTHER PARTIES TO JUSTIFY CLAIMS FILED. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

PATIENT/RESPONSIBLE PARTY SIGNATURE

DATE SIGNED