PATIENT INFORMATION:

Please complete all the information that applies!! Thank you

LAST NAME:_____ MI:_____ FIRST:_____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___)____-_____ Work Phone: (___)____-_____ Cell Phone: (___)____-_____

Emergency Contact: _____ Phone #: (___)____-_____

SS#: _____/_____/_____ Birth Date: ___/___/_____ Sex: M__F__ Occupation: _____

Referring or Primary Care Dr.: _____ Phone #: (___)____-_____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION:

Primary Insurance Carrier: _____ Policy #:_____

Secondary Carrier: _____ Policy #: _____

Name of Employer/Address: _____

Name of Policy Holder: _____ SS #: _____/_____/_____ DOB: _____/_____/_____
(if not patient)

Relationship to Patient: _____ Home Phone: (___)____-_____ Cell Phone: (___)____-_____

Home Address: _____ City: _____ State: _____ Zip: _____

I ACKNOWLEDGE THAT I HAVE BEEN INFORMED THAT THE PRACTICE OF DR. ROGER KOREEN HAS IMPLEMENTED THE PRIVACY RULE AS REQUIRED BY HIPPA TO PROTECT MY HEALTH INFORMATION AND THAT I MAY REVIEW THE PRIVACY NOTICE AT MY REQUEST.

PATIENT SIGNATURE: _____ DATE: _____

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Medicare Patients ONLY: Dr. Koreen participates in the Medicare Program and accepts assignment of all claims. Patients are responsible for meeting their annual $131.00 deductible and for paying the 20% co-payment. We will file with secondary carriers, however, if we are not reimbursed within 60 days, the patient will be billed. The patient is also responsible for any non-covered cosmetic or "not medically necessary" service and payment is expected at the time of the visit.

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to the payor if they require it for the proper consideration of a claim. **Please read and sign the following statement:**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be paid to Dr. Koreen.

SIGNATURE ON MEDICARE CARD: _____ DATE: _____