

# BLANCHARD VALLEY MEDICAL ASSOCIATES

## PATIENT INFORMATION

PATIENT LEGAL NAME \_\_\_\_\_ PHONE # \_\_\_\_\_  
Last First Middle

ADDRESS \_\_\_\_\_  
Street City State Zip

SS# \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

MARITAL STATUS: Single  Married  Widowed  Divorced  SEX: Male  Female

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Street City State Zip

SPOUSE'S NAME (PARENTS NAME IF A MINOR) \_\_\_\_\_

ADDRESS (IF DIFFERENT FROM ABOVE) \_\_\_\_\_  
Street City State Zip

IN CASE OF EMERGENCY NOTIFY \_\_\_\_\_ PH# \_\_\_\_\_

### MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to the Doctor or Group indicated on the claim for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize Medicare to furnish to the above named Doctor or Group any information regarding my Medicare claims under Title XVIII of the Social Security Act.

### COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand I am financially responsible for any balance not covered by my insurance carrier.

I acknowledge and agree that I have received a copy of Blanchard Valley Medical Associates' Notice of Privacy Practices and Financial Policy.

A copy of this signature is as valid as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date