

**PATIENT INFORMATION**  
**PLEASE FILL IN ALL THE BLANKS**

**Patient's Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Age** \_\_\_\_\_  
Home  
Address \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Social Security #** \_\_\_\_\_ **Driver's License #** \_\_\_\_\_ **Tele. #** \_\_\_\_\_  
**E-mail Address** \_\_\_\_\_ **Home** \_\_\_\_\_  
\_\_\_\_\_ **Tele. #** \_\_\_\_\_  
\_\_\_\_\_ **Cellular** \_\_\_\_\_

**Patient Employed:** \_\_Yes \_\_No. **Occupation** \_\_\_\_\_  
**Employer's Name** \_\_\_\_\_ **Tele. #** \_\_\_\_\_  
\_\_\_\_\_ **Business** \_\_\_\_\_  
**Employer's Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**May we contact you at work?** \_\_Yes \_\_No

**Spouse's Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SS#** \_\_\_\_\_  
**Spouse's Occupation** \_\_\_\_\_ **Employer's Name** \_\_\_\_\_ **Tele. #** \_\_\_\_\_  
\_\_\_\_\_ **Business** \_\_\_\_\_

**Who** is financially responsible for this bill? \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Whom** may we contact in case of emergency? \_\_\_\_\_ **Tele. #** \_\_\_\_\_

**Whom** may we thank for referring you to us? \_\_\_\_\_

**MEDICAL INSURANCE:** (PLEASE Notify us if covered by more than one policy)

**Primary Insurance Co.** \_\_\_\_\_ **Tele. #** \_\_\_\_\_  
**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Name of Insured** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_  
**Relationship To Patient** \_\_\_\_\_ **Insured's DOB:** \_\_\_\_\_ **Insured's Empl:** \_\_\_\_\_ **Lab:** \_\_\_\_\_

**Secondary Insurance Co.** \_\_\_\_\_ **If patient not covered under any secondary insurance, initial here:** \_\_\_\_\_  
**Tele. #** \_\_\_\_\_  
**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Name of Insured** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_

**NOTIFICATION CONSENT:**

I give permission to contact me at:  Home  Cell  Work  Fax  E-mail **Authorize Initials** \_\_\_\_\_  
Contact information if different than above: \_\_\_\_\_  
Is it okay to leave a message?  Yes  No **Authorize Initials** \_\_\_\_\_  
Is it okay to give information to other than myself?  Yes  No **Authorize Initials** \_\_\_\_\_

**FINANCIAL AGREEMENT AND AUTHORIZATIONS:**

I HEREBY AUTHORIZE and direct payment to ROBERT L. TRUE, M.D., for the surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for the payment of any remaining balance and for charges not covered by this authorization and/or my insurance. I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to ROBERT L. TRUE, M.D. I hereby authorize photocopies of these "signed authorizations" to be as valid as the originals. I hereby certify that the above information and statements are true and accurate:

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_