Patient Information

DOCTOR OF RECORD
Jeffrey T Shaver MD

PATIENT NAME (First Name, Middle Initial, Last Name)	PATIENT ID (Office Use Only)	FIRST PHONE (HOME)	SECOND PHONE (WORK)	THIRD PHONE (MOBILE)
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX (M or F) [ ]M [ ]F	MARITAL STATUS [ ]Married [ ]Single [ ]Other
CITY, STATE, ZIP	AGE	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHON
EMPLOYER		OCCUPATION	PATIENT E-MAIL ADDRESS	
REFERRING DOCTOR NAME & ADDRESS				
PRIMARY CARE DOCTOR NAME & ADDRESS				

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)		
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP	SEX (M or F)	PATIENT'S RELATION TO RES
EMPLOYER	OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [ ] Other (complete below

INSURANCE COMPANY NAME	COPAY AMOUNT	INSURED'S NAME (First Name, Middle Initial, Last Name		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [ ] Other (complete below)

INSURANCE COMPANY NAME		INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Pharmacy Information

Name	Phone #	Fax #
Address	CITY, STATE, ZIP	

Authorization and Acknowledgement

Patient/Custodial parent Signature:

I hereby apply for treatment by the physicians of this practice and or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled to this practice. I understand that payment is due at the time of service and that I am financially responsible for all charges, whether or not paid by insurance. **I have been given a copy of the HIPPA Privacy Statement.**

Signature of Patient / Parent / Guardian

Printed Name

Date