BILLING & INFORMATION FORM

LAST NAME ______________________________ FIRST NAME_____________________________ DOB______________

SEX: M F SOCIAL SECURITY # ________-_______-__________ MARITAL STATUS ______________

RACE: ASIAN AFRICAN AMERICAN WHITE HISPANIC PACIFIC ISLANDER OTHER LANGUAGE: _______________

ADDRESS: ____

HOME PHONE: __________________________ CELL PHONE ______________________________ PRIMARY? HOME/CELL

E-MAIL: _______________________________ EMERGENCY CONTACT/RELATION/NUMBER__________________________

EMPLOYER INFORMATION

COMPANY NAME _____________________________________ WORK NUMBER ____________________________________

ADDRESS ____

BILLING INFORMATION

NAME OF RESPONSIBLE PARTY ____ RELATION: _______________________

ADDRESS: ____

DOB: __________________________ PHONE NUMBER __________________________________

INSURANCE INFORMATION

INSURANCE NAME____ COPAY AMOUNT ____________________________

SUBSCRIBER NAME ____ RELATIONSHIP ____________________________

POLICY/ID # ____ GROUP # _________________________________

SECONDARY INSURANCE ______________________________________ COPAY AMOUNT ____________________________

SUBSCRIBER NAME ____ RELATIONSHIP____________________________

POLICY/ID # ____ GROUP # _________________________________

SUBSCRIBER DATE OF BIRTH (IF NOT SELF) ________________________ SOCIAL SECURITY # _______________________

HOW DID YOU HEAR ABOUT US? NEWSPAPER FRIEND FORMER PATIENT FACEBOOK OTHER ________________

I authorize the release of any medical information necessary to process this claim (REQUIRED) Signature: _____________________________ Date ______	I authorize payment of medical benefits to my physician for services provided (REQUIRED) Signature ___________________________ Date _________

I authorize SKYVIEW FAMILY MEDICINE to release my health information to the follow people:

Please print name/relationship: ____

Signature _______________________________________ Date _______________________________