MICHAEL TEIGER, M.D. PATIENT INFORMATION

Work Related or MVA Accident ______________________:

Patient Information:

Name (Last, First, Middle) ______________________

Birthdate ________ Age ____ Sex M/F ACCT# ________

Address ______________________

City, State, Zipcode ______________________

Home Phone ______________________

Work Phone ______________________

Social Security No. ______________________

Marital Status ______________________

Occupation ______________________

Employed by ______________________

Address ______________________

City, State, Zipcode ______________________

Primary Care Physician: ______________________

Referring Physician ______________________

Primary Guarantor:

Name (Last, Frist, Middle) ______________________

Address ______________________

City, State, Zipcode ______________________

Emergency Contact:

Name ______________________ Telephone ______________ Cell Phone: ______________

Primary Insurance:

Insurer ______________________

Insured's Name ______________________

Address ______________________

City, State, Zip Code ______________________

Patient's Relation to the Insured ______________________

Insured's ID No. ______________

Insurance Phone # ______________

Insured's Employer ______________

Insured's Employer Address ______________________

Insurance Phone # ______________

Secondary Insurance:

Insurer ______________________

Insured's Name ______________________

Address ______________________

City, State, Zip Code ______________________

Patient's Relation to the Insured ______________________

Insured's ID No. ______________

Insurance Phone# ______________

Insured's Employer ______________

Insured's Employer Address ______________________

Insurance Phone # ______________

I hereby authorize direct payment of surgical/medical benefits to Michael B.Teiger, M.D., F.C.C.P for services rendered by him or her in persons or under his/her supervision.
I understand that I am financially responsible for any balance not covered by my insurance.
I certify that the information given by me in applying for payment is correct.
I authorize release of all records on request.
I request that payment of authorized benefits be made on my behalf.

Patient Signature: ______________________________________

Date: ______________________