PATIENT INFORMATION **FILL OUT COMPLETELY (NO BLANKS)** **GARY P. GOODFRIED, MD PA**

PATIENT NAME		DATE OF BIRTH
ADDRESS	City	State/ZIP
HOME PHONE	CELL PHONE	WORK PHONE
EMAIL	SEX (M or F)	SS#
WHO REFERRED YOU	PRIMARY DOCTOR	
LANGUAGE	RACE	ETHNICITY

RELEASE OF INFORMATION WHO CAN HAVE ACCESS TO MY CARE AND RECORDS

NAME	RELATION TO PT	ALL RECORDS [ ]	OTHER (SPECIFY)
NAME	RELATION TO PT	ALL RECORDS [ ]	OTHER (SPECIFY)

PRIMARY INSURANCE

INSURANCE COMPANY NAME	POLICY NUMBER

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE) [ ] PATIENT [ ] OTHER IF OTHER COMPLETE BELOW

OTHER [ ] SPOUSE [ ] PARENT [ ] GUARDIAN

INSURED'S NAME	INSURED'S EMPLOYER	DATE OF BIRTH
ADDRESS SSA[ ]	STATE	ZIP
INSURED'S PHONE	SEX (M or F)	SS#

SECONDARY INSURANCE

INSURANCE COMPANY NAME	POLICY NUMBER

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE) [ ] PATIENT [ ] OTHER IF OTHER COMPLETE BELOW

OTHER [ ] SPOUSE [ ] PARENT [ ] GUARDIAN

INSURED'S NAME	INSURED'S EMPLOYER	DATE OF BIRTH
ADDRESS SSA[ ]	STATE	ZIP
INSURED'S PHONE	SEX (M or F)	SS#

AUTHORIZATION AND ACKNOWLEDGEMENT

I/We hereby state that the above information is true and correct to the best of my/our knowledge. I/We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payers, as required for certain claims filed.

I/We authorize direct payment to be made to the above named practice for any all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility cannot be verified, I am responsible for all charges incurred.

Signature of Patient/Guardian Printed Name Date