R. PATRICK ABERGEL, M.D.

Patient Information

Code

Account Number

Patient	PLEASE FILL OUT CLEARLY & COMPLETELY	Home Phone
Mr. Mrs. Miss/Ms. Last	First	Middle
Home Address	Apt # City	State Zip
Social Security #	Date of Birth Age Sex	Driver's Lic. #
Patient's Employer	Work Address	Work Phone
Email Address	Mobile Phone #	Pager #
Spouse Name	Spouse Employer Name & Address	Work Phone
Emergency Contact	Address	Phone

REFERRED TO THIS OFFICE BY _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

PRIMARY INSURANCE	PLEASE LIST ALL HEALTHCARE INSURANCE COMPANIES WHICH COVERS THIS PATIENT	
Name	Policy #	Subscriber
Group #	Subscriber Social Security #	
Insurance Company Address		

SECONDARY INSURANCE		
Name	Policy #	Subscriber
Group #	Subscriber Social Security #	
Insurance Company Address		

RESPONSIBLE PARTY	Mr. Mrs. Miss/Ms. Last	First	Middle
Address			Phone
Occupation	Employers Name & Address		Work Phone

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

METHOD OF PAYMENT Cash _____ Check _____ Credit Card _____

PLEASE READ & SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to _____ and I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I furthur agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE _____ DATE _____