

IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

PATIENT INFORMATION

Your Name (Last, First, Middle Initial)		Date of Birth	
Address			
City	State	Zip	
Telephone			
() Social Security #			
Employer's Name		Telephone	
()			
Employer's Address			
City	State	Zip	
Please Indicate if Applicable:		Date of Injury	
<input type="checkbox"/> AUTO ACCIDENT			
<input type="checkbox"/> WORKER'S COMPENSATION			

INSURANCE INFORMATION

Your PRIMARY Insurance Company's Name		
Primary Insurance Company's Address		
City	State	Zip
Policyholder's ID Number		Group Plan Number
Your SECONDARY Insurance Company's Name		
Secondary Insurance Company's Address		
City	State	Zip
Policyholder's ID Number		Group Plan Number

"DETACH HERE AND RETURN ABOVE STUB"

FOR HOSPITAL OR OTHER FACILITY PATIENTS

YOU COULD RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED

TOTAL DIAGNOSTIC OR TREATMENT COSTS

PHYSICIAN OR PROVIDER'S FEE

HOSPITAL CHARGES OR OTHER FACILITY

This statement is not a duplicate charge, but a separation of the facility and physician or provider's fees. These services were provided while you were under our care, or at the request of your other physicians or providers.

Your bill from the facility may include a separate charge for use of its equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in a hospital or other facility.

If you have any questions concerning your bill, please call our office and we will be happy to assist you.

IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE PHONE NUMBER ON THE REVERSE SIDE.