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Patient Information:

Patient Name: _____

Date of Birth: _____ Sex: Male _____ Female _____

Patient's Social Security Number: _____

Address: _____
Street

_____ City State Zip Code

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____

Insurance Information:

Insurance Company: _____

Insurance Policy Number: _____

Group Number: _____

Insurance Policy Owner's Name: _____

Insurance Policy Owner's Date of Birth: _____

Patient's Relationship to Policy Owner: Self _____ Child _____ Other _____

If Patient is a Child: (under 18)

Parent/Legal Guardian's Name: _____

Parent/Legal Guardian's Date of Birth: _____

Parent/Legal Guardian's Cell Phone #: _____

Parent/ Legal Guardian's Work #: _____

_____ I authorize my child may be seen and treated in my absence

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. Payment is expected from you, at the time of service for your "part" of the charges. We accept only cash or check. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes Johanna Baeuerle, MD to release medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to Johanna Baeuerle, MD when an assigned claim is filed. It is the policy of this office that the adult presenting a child for treatment is responsible for the payment of the patient's portion at the time of service.

Signature of Patient/Parent/Legal Guardian

Date