

## Patient Information Form

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Date: _____	
Patient Name (Last / First / MI): _____	Maiden Name: _____
Street Address: _____	Phone Number: _____
City: _____	State: _____ Zip _____
Birthdate: _____	SSN: _____
Employer: _____	Occupation: _____
Employer's Address: _____	Phone Number: _____
Marital Status: (Circle One)    M    S    W    D	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Emergency Contact: _____	Phone Number: _____

Is Patient Responsible Party: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Retired: _____
Spouse / Parent Info: _____	Phone Number: _____
Address: _____ City: _____	State: _____ Zip: _____
Birthdate: _____	SSN: _____
Employer: _____	Occupation: _____
Employer's Address: _____	Phone Number: _____
City: _____	State: _____ Zip: _____
Relationship to Patient: <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child <input type="checkbox"/> Parent	<input type="checkbox"/> Other: _____

Referring Physician: _____	Phone Number: _____
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Primary Insurance Company: _____	
Street Address: _____	Phone Number: _____
City: _____	State: _____ Zip: _____
ID #: _____	Group #: _____
Name on Policy: _____	Through Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No

Primary Insurance Company: _____	
Street Address: _____	Phone Number: _____
City: _____	State: _____ Zip: _____
ID #: _____	Group #: _____
Name on Policy: _____	Through Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No

Unless you are a member of an insurance company that is contracted with the physician, payment for services are expected on the day of the visit. Payment may be made by check, cash or credit card.

I authorize physician to release any information acquired in the course of my examination or treatment to my insurance company in order to file a claim. I also understand that there may be a balance due from me after my insurance pays their portion. I also authorize payment directly to and assign to physician any surgical/medical benefits. A photostatic copy of this release shall be valid as the original. I understand that if my account is not paid when due. I will be responsible for all costs incurred in the collection process of my account. I further understand that my account will be reported to a credit bureau.

Physician does not deny benefits or service because of race, color, national origin, age, sex, disability, religious or political beliefs. If you feel you have been discriminated against, you may file a Complaint of Discrimination with the Administrator of this facility. You will not suffer any penalty because you file a complaint.

Date: \_\_\_\_\_ Signature of Patient / Responsible Party: \_\_\_\_\_