

RALEIGH ENDOCRINE ASSOCIATES

ENDOCRINOLOGY DIABETES & METABOLISM

Today's Date _____/_____/_____

Name _____ E-Mail _____

Date of Birth _____/_____/_____ Sex: Male or Female Social Security Number _____

Mailing Address _____ Apt # _____

City _____ State _____ Zip Code _____

Best number to contact you (_____-_____-_____) Home Phone (_____-_____-_____) _____

Name of Parent or Guardian with whom the patient resides if minor _____

Did a Doctor/PA/NP refer you here? Yes or No If so, who _____ City _____ State _____

Primary Care Physician (if different than above) _____

Pharmacy of Choice _____ Phone Number or Location _____

In case of an Emergency, Whom should we notify? _____

Relationship to Patient _____ Phone Number (_____-_____-_____) _____

INSURANCE COVERAGE INFORMATION -Primary

Insurance Name _____ PolicyID# _____ Group# _____

Subscriber Name _____ DOB ____/____/____ Relationship: _____

INSURANCE COVERAGE INFORMATION – Secondary

Insurance Name _____ PolicyID# _____ Group# _____

Subscriber Name _____ DOB ____/____/____ Relationship: _____

INSURANCE COVERAGE INFORMATION – Tertiary

Insurance Name _____ PolicyID# _____ Group# _____

Subscriber Name _____ DOB ____/____/____ Relationship: _____

My signature below indicates that all information I have proved is correct and accurate to the best of my knowledge

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned physician of the Surgical and/or Medical Benefits, if any otherwise payable to me for their services as described below but not to exceed the reasonable and customary charge for those services. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Raleigh Endocrine Associates for any services furnished to me by that Association.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to the Health Center Financing Administration and its agents and to specific insurance carriers, third party payers or others involved in processing and collecting of this claim as needed to determine these benefits or benefits for related services.

FINANCIAL RESPONSIBILITY: The undersigned guarantees payment to Raleigh Endocrine Associates for services rendered in the event insurance does not cover all fees.

Date: ____/____/____ Signature: _____