

# BLOSSOMWOOD MEDICAL, P.C.

## Patient Information

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PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
ADDRESS \_\_\_\_\_ AGE \_\_\_\_\_ SEX (M OR F) \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ SS# \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ (S M W D)  
EMAIL \_\_\_\_\_  
EMPLOYER (parent if patient is minor) \_\_\_\_\_ PHONE \_\_\_\_\_  
EMERGENCY CONTACT NAME \_\_\_\_\_ PHONE \_\_\_\_\_  
SPOUSE NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SS# \_\_\_\_\_  
SPOUSE EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_  
REFERRED BY (physician) \_\_\_\_\_ PHONE \_\_\_\_\_

RESULT OF ON THE JOB INJURY \_\_\_\_\_ RESULT OF ACCIDENT \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_

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### PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN SELF

NAME \_\_\_\_\_ SS# \_\_\_\_\_  
ADDRESS (if different from patient) \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

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### INSURANCE INFORMATION

PRIMARY _____	PHONE _____
ADDRESS _____	CITY/STATE/ZIP _____
NAME OF INSURED _____	RELATIONSHIP TO PATIENT _____
INS ID# _____	GROUP # _____
SS# _____	DRIVERS LIC # _____
SECONDARY _____	PHONE _____
ADDRESS _____	CITY/STATE/ZIP _____
NAME OF INSURED _____	RELATIONSHIP TO PATIENT _____
INS ID# _____	GROUP # _____
SS# _____	DRIVERS LIC # _____

If Blossomwood Medical, P.C., is a provider for your insurance company (we accept assignment), the Guarantor or Responsible Party for the patient's account will be required to pay all co-pays and/or deductibles as outlined in their insurance policy.

For all other insurance companies, the Guarantor or Responsible Party of the patient will be completely and totally responsible for charges incurred for all services rendered according to Blossomwood Medical, P.C.'s Fee Schedule.

I hereby authorize payment of medical benefits directly to physician of benefits due me or my dependents for services rendered. I further authorize the physician to release any information required to process insurance claims. I understand that I am responsible for any amount not covered by insurance. Should my account become delinquent, I will be responsible for any collection fees, attorney fees, court costs, etc.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_