The Back and Neck Clinics

BELLAIRE • PEARLAND

Dr. Abraham G. Thomas, M.D.

PATIENT DEMOGRAPHIC INFORMATION

Name: _____ D.O.B. _____

Social Security#:_____ Sex: M /_/ F /_/ Marital Status: Single /_/ Married /_/ Divorced /_/ Widowed /_/

Address:_____City:_____State:_____Zip:_____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation:_____

Address:_____Phone #: _____

In case of an emergency, whom may we notify? _____Ph#:_____ Relation: _____

Who referred you to Dr. Thomas?_____

PRIMARY INSURANCE

Please Provide your Insurance Card and your Photo Identification/Driver's License

Guarantor:_____

Relation to patient: _____

Address if different from patient: _____

Guarantor Employer: _____

Insurance Company: _____

Member ID#: _____Group#:_____ Contact#: _____

SECONDARY INSURANCE

Please Provide your Secondary Insurance Card

Guarantor:_____

Relation to patient: _____

Address if different from patient: _____

Insurance Company: _____

Member ID#: _____Group#:_____ Contact#: _____

WORKERS' COMPENSATION CARRIER

Please Provide your Photo Identification/Driver's License

Worker Compensation Carrier: _____ Date of Injury: _____

Carrier address: _____

Phone#: _____ Adjustor's Name: _____

Claim#: _____

ASSIGNMENT, AUTHORIZATION AND RELEASE

PRIVATE INSURANCE PATIENTS

I, the undersigned, have INSURANCE coverage with _____ and assign directly to Dr. Abraham G. Thomas all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian **Date**

MEDICARE PATIENTS

I request that payment of authorized MEDICARE benefits to be made to me or on my behalf to Dr. Abraham G. Thomas for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for these services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim, If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted forms, my signature authorizes releasing of the information to the insurer or the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier, as full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature **Date**

WORKER'S COMPENSATION PATIENTS

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment in the event that my claim for WORKER'S COMPENSATION benefits is denied.

_____ _____

Patient's Signature **Date**