

SETH A. BISER, M.D., P.C. - PATIENT INFORMATION

Welcome to our office! Please PRINT all answers on this form.

How did you find out about our office?					
Patient's LAST NAME	First Name & M.I.	Title/Suffix	Sex M F	Birth Date	Social Security #
Primary Care Doctor/Phone # <input type="checkbox"/> I have no primary doctor		Optometrist / Optician		Other Physician(s) needing reports	
Home Address		City / State / Zip		Home # () Cell # () Email:	
Occupation		Employer / Business Name		Work # ()	
Check One: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced					
If married, name of: <input type="checkbox"/> Spouse			Spouse or Parent's Employer		Work Phone # ()
If under 18, name of: <input type="checkbox"/> Parent /Guardian					
Emergency Contact		Relationship		Phone # ()	
Who is responsible for payment, if not patient?					
Primary Insurance Company		ID and Group#		Policy Holder's Name (if not patient) Tel #	
Secondary Insurance Company		ID and Group#		Policy Holder's Name (if not patient) Tel #	
Is your condition work-related? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, workers' comp carrier:			
Is your condition due to an auto accident? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, auto insurer name/phone:			

All professional services rendered are charged to the patient. Forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance.

I authorize my insurance carrier or company to make payment directly to Seth A. Biser, M.D., for professional services rendered. I authorize Dr. Biser to release to my insurance carrier or company any medical information required to process my insurance claims. I authorize Dr. Biser to send a consultation report to my doctor should this prove necessary.

I have read, understand, and agree to all of the above.

Date: _____ Signature: _____

If signer is not patient, name of signer and relation to patient: _____