

Patient Information

Fred E. Clayson, M.D.

Date _____

Patient's Name _____
Last First Middle

Date of Birth _____ Age _____ Sex _____

Child Single Married Divorced Widow(er)

Address _____
Number & Street City State Zip

Home Phone _____ Patient Social Security # _____

Work Phone _____

Responsible Party (If other than patient) _____

Who is your Primary Care Physician?

Patient or Responsible Party Employer _____

Employer Address _____

Whom may we thank for your referral? _____

Has any member of your family ever been treated at this office? _____

If so, who? _____

1st Insurance Company _____

Group # _____ ID # _____

Cardholder Name _____

Relationship of patient to Cardholder _____

Cardholder Employer _____

2nd Insurance Company _____

Group # _____ ID # _____

Cardholder Name _____

Relationship of patient to Cardholder _____

Cardholder Employer _____

- PLEASE COMPLETE BOTH SIDES OF FORM -

Nearest Relative, not living with you,

Name _____ Phone: _____

Address: _____

Number & Street

City

State

Zip

Relationship to patient: _____

Authorization For Treatment and Financial Agreement:

I authorize treatment of the person named as patient and agree to pay for all services rendered to patient including but not limited to any amounts not paid by my insurance company. I will be responsible for all copayments, deductibles, coinsurance and/or noncovered services. I request payment of authorized benefits to Dr. Clayson on my behalf for any services furnished to me by Dr. Clayson. I authorize Dr. Clayson to release to my insurance company any information needed to determine benefits for my services.

I agree to pay a finance charge of one and one half (1 1/2%) per month on all amounts due and owing to Dr. Clayson. In the event that it becomes necessary to turn over any unpaid balance on my account to a collection agency, I agree to pay up to a 33.3% collection expense incurred by Dr. Clayson. In addition, if legal action should become necessary in order to collect a delinquent amount, I agree to pay reasonable attorney fees or other such costs as the court deems proper.

Signature _____ Date _____