CHART NUMBER -

Patients Name	Date of Birth	Age	Marital Status	Person Responsible for Charges

Street Address	City	State	Zip	Home Phone

Your Employer	Your Occupation	Length of Employment	Your Cell Phone Number

Employer Address	City	State	Zip	Work Telephone

Spouse/Guarantor Name	Spouse/Guarantor Employer	Length of Employ	Work Telephone

Name of Insurance Co. Effective Date	Policy Number/Group Number	May we leave a message for you to return our call at your? Home Yes ☐ No ☐ Work Yes ☐ No ☐ Cell phone Yes ☐ No ☐

Your Social Security Number	Spouse's/Guarantor's Name, Date of Birth &Social Security Number

Whom may we share health information with:	Whom may **we not** share health information with:

Family Physician	Referred by	Emergency Name, Number, and Relationship (not living with you)

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE CARRIER PAYMENTS**. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGUARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR ALL SERVICES OR CO-PAYS WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. *YOU WILL BE BILLED SEPERATELY BY THE PATHOLOGIST OR LABORATORY FOR BLOOD WORK AND CULTURES.***

_____ _____

Signature Date

INSURANCE AUTHORIZATION ASSIGNMENT

I hereby authorize Dr. Vick to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician all payments for medical services rendered to my dependents and myself. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Signature Date

George W. Vick, II, M.D., F.A.C.O.G.
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