J. Chris Beckman, M.D., PLLC

Today's Date: ____________________ How did you hear about our office? ________________________

PERSONAL INFORMATION:

NAME: ____ ________

FIRST MIDDLE LAST SEX (M / F)

____

STREET ADDRESS CITY STATE/ZIP

(_____) ______________ (_____) ______________ (_____) ______________

HOME TELEPHONE WORK PHONE CELL PHONE

DATE OF BIRTH ______________ SOCIAL SECURITY NUMBER ______________ RACE (White, Black, Hispanic, Other) ______________

EMAIL ADDRESS ______________________ PATIENT'S EMPLOYER ______________________

LANGUAGE (English, Spanish, etc.) ______________________ ETHNICITY (American, African-American, Mexican, etc.) ______________________

SPOUSE'S NAME ______________________ SPOUSE'S DATE OF BIRTH ______________________

SPOUSE'S EMPLOYER ______________________ (_____) SPOUSE'S WORK NUMBER ______________________

In the event of an emergency please contact:

Name: ______________________ Relationship: ______________

Home Phone: ______________ Work Phone: ______________

Where do you prefer to receive calls? _____ Home_____ Work _____ Mobile

May we leave information on your answering machine or voice mail? _____ Yes _____ No

With whom may we share your health information? ______________________________

Pharmacy name: ______________________ Pharmacy address ______________________

BILLING INFORMATION (Who will pay for services not covered by insurance?)

Name ______________________ Relationship to Patient ______________

Address ____

Date of Birth ______________ Social Security # ______________

Work Number ______________ Home Number ______________

INSURANCE INFORMATION (Please provide insurance card for us to copy)

PRIMARY INS CO ______________

ID # ______________ Group # ________

Insured's Name ______________

Insured's DOB ______________

Relationship to Patient SELF SPOUSE CHILD

Employer ______________

Insured's Social Sec # ______________

SECONDARY INS CO ______________

ID # ______________ Group # ________

Insured's Name ______________

Insured's DOB ______________

Relationship to Patient: SELF SPOUSE CHILD

Employer ______________

Insured's Social Sec # ______________

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to J. Chris Beckman, M.D., PLLC. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.

______________________________ ______________

Patient's Signature (Parent's signature if under 18) Date