04-29-2008

Patient's
Last name : ______________________ First name : ______________ MI : ____

Address : ____

City : ______________________ State code : ____ Zipcode : ____________

Referral Dr : ______________________ Sex (M/F) : ____ Marital Status : ____ S M D W

Birthday : ______/______/______ Social sec : ______/______/________

Home Phone : (______)______________ Work Phone : (______)______________

Emergency : ______________________ Emer Phone : (______)______________

Email : ______________________ Cell Phone : (______)______________

== Primary Insurance Coverage ======== **== Secondary Insurance Coverage ========**

Company : ______________________ Company : ______________________

Insured name : ______________________ Insured name : ______________________

Relationship : ________ DOB: ________ Relationship : ________ DOB: ________

Co-pay amount : ______________________ Co-pay amount : ______________________

Policy number : ______________________ Policy number : ______________________

Group number : ______________________ Group number : ______________________

Employer : ______________________ Employer : ______________________

== Guarantor Information ===

Guarantor : ____

Address : ____

City : ______________________ State code : ____ Zipcode : __________

Telephone # : (______)______________ Miscellaneous : ______________________

Patient's Authorization

I authorize DR. DAVID STROBEL to apply for benefits on my behalf for services rendered by DR. DAVID STROBEL. I request payment from my insurance company be made directly to DR. DAVID STROBEL. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

______________________________________ ____________________

Signature of Subscriber or Beneficiary Date