

Eric O. Kortz, M.D.

Richard L. Tillquist, M.D.

Thomas G. Heffron, M.D.

**PATIENT INFORMATION**

**Patient E-mail Address:** \_\_\_\_\_

**Requesting/Referring Physician** \_\_\_\_\_ **Primary Care Physician** \_\_\_\_\_

Name (legal): Mr. Mrs. Ms. First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell/Pager \_\_\_\_\_

SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Marital Status: S M W D

Patients Occupation: \_\_\_\_\_ Patients Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Spouse/Parent Name: \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse/Parent Employer: \_\_\_\_\_ Spouse/Parent Work Phone #: \_\_\_\_\_

Person Responsible for Payment of Services (if different from patient): \_\_\_\_\_

**Emergency Contact:** Relative/Friend, **not living with you** (in case we are unable to contact you, or need to contact someone regarding your care in an emergency).

Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Long Term Contact:** Relative/Friend, **not living with you** (Should we need to contact you in future years if you have moved from the address given in patient info above).

Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE INFORMATION**

**Legible Copy of Ins. Card**

**Copy of Drivers License**

**PRIMARY Insurance Company:** \_\_\_\_\_ Subscribers Name: \_\_\_\_\_

Address or P.O. Box (for claims): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_

Relationship: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_ **Employer Carrying Insurance:** \_\_\_\_\_

**IF ACCIDENT:**  Work Comp  Auto: Date of Injury \_\_\_\_\_ Claim No. \_\_\_\_\_

**SECONDARY Insurance Company:** \_\_\_\_\_ Subscribers Name: \_\_\_\_\_

Address or P.O. Box (for claims): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_

Relationship: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_ **Employer Carrying Insurance:** \_\_\_\_\_

**IF ACCIDENT:**  Work Comp  Auto: Date of Injury \_\_\_\_\_ Claim No. \_\_\_\_\_

\* I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES THIS OFFICE, AS A SERVICE TO ME, WILL BILL MY INSURANCE. I FURNISH THIS OFFICE WITH ALL INFORMATION NECESSARY TO BILL MY INSURANCE. ANY BALANCE AFTER INSURANCE HAS PAID OR DENIED IS DUE BY ME. ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE REASONABLE COST OF COLLECTION, TO INCLUDE ANY ATTORNEY FEES.

\* I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN/SUPPLIER FOR THESE SERVICES AND ALL FUTURE CLAIMS. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

SIGNATURE \_\_\_\_\_ (signed) Date: \_\_\_\_\_