

LOUISE I. BUHRMANN, MD, PA

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Phone (407) 671-2258 / Fax (407) 671-2675

PATIENT INFORMATION

Date _____ New Patient _____ or Update of Information _____

How did you hear of our office? _____

Patient Name (first, middle, last) _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Alternate Phone _____

Marital Status _____ Gender _____ Date of Birth _____ Age _____

Social Security # _____ Employer _____

School (If currently a student) _____

Emergency Contact _____ Relationship to patient _____

Home Phone _____ Work Phone _____

If patient is under the age of 18 please complete parent/guardian information below:

Mother's Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Mother's Home Phone _____ Mother's Work Phone _____

Father's Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Father's Home Phone _____ Father's Work Phone _____

Who does patient live with? Mother _____ Father _____ Both _____ Other _____

If Guardian is someone other than listed above: Name _____

Address _____ Phone _____

PRIMARY INSURANCE POLICY

Name of Insurance Company_____

Name of Managed Care Company_____

Address to Mail Claims_____

Phone Number for Benefit/Precert Information_____/_____

Name of Insured's Employer_____

Name of Policy Holder_____SS#_____

Date of Birth of Policy Holder_____Group Name/Number_____

SECONDARY INSURANCE POLICY

Name of Insurance Company_____

Name of Managed Care Company_____

Address to Mail Claims_____

Phone Number for Benefit/Precert Information_____/_____

Name of Insured's Employer_____

Name of Policy Holder_____SS#_____

Date of Birth of Policy Holder_____Group Name/Number_____

I authorize information to be sent to my insurance company for purposes of payment. I also agree to pay for services rendered. If it becomes necessary to turn my account over to a collection agency, I understand that I will be responsible for all reasonable fees incurred to collect the account. This includes attorney fees and court costs.

Signature of Patient_____Print_____

Signature of Insured_____Print_____

Please have your insurance card(s) ready to be photocopied.

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SIGNATURE ON FILE / FINANCIAL AGREEMENT

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my Insurance Companies.

I understand that I am responsible for my bill.

I authorize my doctor to act as my agent in helping me to obtain payment from my insurance companies.

I authorize payment direct to my doctor.

I permit a copy of this authorization to be used in place of the original.

I am responsible for any insurance deductibles and co-payments.

If I am not using insurance I understand that I am responsible for payment in full at the time of my appointment.

I understand that I may be charged for appointments canceled with less than 24 hours notice.

Name (Please print) _____

Signature _____ **Date** _____