PATIENT'S INFORMATION

DATE_____

Patient's Name _____ Spouse _____

Address: _____ Apt. # _____

City _____ State _____ Zip _____

Home (____) _____ Cell Ph: (____) _____ Birth Date _____ Age _____

Social Security # _____ Sex (Male / Female)

Family Doctor_____ Phone (____) _____

Emergency Contact _____ Phone (____) _____

Patient's Employer _____ Occupation _____

Address _____ Work Phone (____) _____

City _____ State _____ Zip _____

How were you referred to this office? _____

MEDICARE EPO/PPO HMO PGLB PRIVATE CASH CO-PAY _____

PRIMARY INSURANCE INFORMATION

Insurance Co. Name _____ Group/Policy # _____

Insurance Address: _____

Insured's Name: _____ Birth Date ____/____/____

Insured's Address: _____

Insured's Social Security # _____

Patient relationship to insured: Self Spouse Child

Please complete the following if insured is other than self.

Insured's Employer: _____ Occupation: _____

Address: _____ Work Phone: (____) _____

City: _____ State _____ Zip _____

SECONDARY INSURANCE INFORMATION

Insurance Co. Name: _____ Group/Policy # _____

Insurance Address: _____

Insured's Name: _____ Birth Date ____/____/____

Insured's Address: _____

Insured's Social Security # _____

Patient relationship to insured: Self Spouse Child

Please complete the following if insured is other than self.

Insured's Employer: _____ Occupation: _____

Address: _____ Work Phone: (____) _____

City _____ State _____ Zip _____

AUTHORIZATION OF MEDICAL BENEFITS

I hereby authorize the _____ Insurance company to pay by check or mail to:

Robert M. Miller, M.D., Inc.
3325 Palo Verde Avenue, Suite 107
Long Beach, CA 90808

The medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assigned and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I further authorize the release of any medical information necessary to process this claim.

Signed: _____