J. Brian Boyd, M.D., Inc.
Patient Information Form

02-03-10

Patient _____
First M.I. Last

☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ male
Date of Birth _____ Age _____ ☐ female

SS # _____-_____-_____

Drivers License # _____

Address _____

City _____ ST _____ Zip _____

Phone # _____ _____
Home Cell

_____ _____
Work Preferred Contact #

E-mail Address _____

Employer _____

Employer's Address_____

City_____ ST _____ Zip_____

Occupation _____

Person Responsible for Bill (complete in full or ☐ same as above)

☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Employer ☐ other_____

Name _____

Address _____

City_____ ST _____ Zip_____

Phone # _____ _____
Home Work

Employer _____

Employer's Address_____

City_____ ST _____ Zip_____

Occupation _____

Authorization for Payment/Release of Medical Records

I authorize release of medical records and payment of benefits to the physician and allow a photocopy of my signature to be used to file insurance. I understand that my insurance may not cover all fees and services provided and I will be responsible for the unpaid balance.

Signature _____ Date _____

Insurance Information

My plan is a: ☐ PPO ☐ HMO ☐ POS (point of service) ☐ EPO ☐ other

Patient's relationship to responsible party:
☐ Self ☐ Spouse ☐ Child ☐ Guardianship ☐ Employee ☐ other_____

Primary Insurance _____

Name of Insured _____ Birthdate _____

Member ID # _____Group # _____

Secondary Insurance _____

Name of Insured _____ Birthdate _____

Member ID # _____Group #_____

Primary Care Physician (complete in full)

Physician's Name _____
First Last

Address _____

City _____ ST _____Zip_____

Phone #_____

How were you referred to this office?

☐ Dr./Hospital ☐ Family/Friend ☐ Insurance ☐ Internet ☐ other _____

Name _____

Person to contact in case of emergency

Name _____Relationship _____

Address _____

City_____ ST _____ Zip_____

Phone # _____ _____
home cell

Authorization for Release of Medical Records

To: _____

I hereby authorize you to release any information including diagnoses and records of any treatment or examination rendered to me during the period of_____ to_____.

Signature_____

Printed name of patient _____

Date _____ Witness _____