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

02-03-10

Patient ______________________________
First M.I. Last

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth ______________ Age ______ ☐ male ☐ 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 ______________________________

Pharmacy Name/ Number/ Location ______________________________

____

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 ____________________