blanzy clinic

14319 Dix-Toledo Road • Southgate, Michigan • (734) 285-0677 • Fax (734) 285-3574

PATIENT INFORMATION

NAME_______________________________________ BIRTHDATE ____________________

ADDRESS _____________________________________ HOME PHONE____________________

CITY ____________________STATE_____ ZIPCODE_________ CELL PHONE ____________________

SOCIAL SECURITY NUMBER ____________________________________

EMAIL ADDRESS:____

CHECK APPROPRIATE : ___ MINOR ___SINGLE ___MARRIED ___DIVORCED ___ WIDOWED ___SEPARATED

PATIENTS OR PARENTS EMPLOYER______________________________ WK PHONE ____________

BUSINESS ADDRESS_________________________CITY______________STATE_____ZIP__________

SPOUSE OR PARENTS NAME_________________________EMPLOYER_______________________

PERSON TO CONTACT IN CASE OF EMERGENCY:____

PHONE # ___________________________________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____________________ RELATIONSHIP ______

ADDRESS____________________________________HOME PHONE______________________

DRIVERS LICENSE # ____________________________ BIRTHDATE ______________________

EMLPLOYER__________________________________ WORK PHONE ______________________

INSURANCE INFORMATION

NAME OF INSURED___________________________________RELATIONSHIP________________

BIRTHDATE________________ SOCIAL SECURITY # ____________________________

NAME OF EMPLOYER______________________________ WORK PHONE__________________

ADDRESS OF EMPLOYER______________________CITY _____________STATE _____ZIP_______

INSURANCE COMPANY____________________________GROUP #____________________

DO YOU HAVE ANY ADDITIONAL INSURANCE COVERAGE? IF YES, COMPETE BELOW:

NAME OF INSURED _______________________________RELATIONSHIP__________________

BIRTHDATE_________________ SOCIAL SEC #________________________

NAME OF EMPLOYER_____________________________WORK PHONE __________________

ADDRESS OF EMPLOYER______________________CITY _____________STATE _____ZIP_______

INSURANCE COMPANY____________________________GROUP #____________________

X____ **DATE** _______________

patient signature or parent signature if minor

HAVE YOU HAD ANY TYPE OF SURGERY? ________________ PLEASE LIST

____

____

PLEASE LIST NAMES AND ADDRESS OF YOUR PREVIOUS DOCTORS

____

____

____

PATIENT INFORMATION REGARDING CHILDHOOD IMMUNIZATIONS, THIS INFORMATION IS NOW REQUIRED BY THE STATE OF MICHIGAN AS PART OF YOUR MEDICAL RECORDS HERE IN OUR OFFICE.

DPT/DTAP ____________________ POLIO____________________

MMR ____________________ HEP B ____________________

SMALL POX _____________

ARE YOU ALLERGIC TO ANY MEDICATIONS? PLEASE LIST

____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND REQUEST PAYMENT OF BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENTS.

X ____ DATE ____________

I UNDERSTAND THAT THE PROVIDERS CHARGE MAY EXCEED THE INSURANCE PAYMENTS, AND IF GREATER THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THAT AMMOUNT.

X ____ DATE ____________