Patient name____DOB:____________

SSN#__________________________ Marital status ________________Sex___________

Street____

City _____________________________________ State ______Zip __________________

Phone (Home or Cell)_________________________Phone (W)_______________________

Referring Doctor____

Emergency Contact______________________Relationship__________Phone____________

Pharmacy ____

Are you? Employed____ Unemployed____ Retired____ Student____

MEDICATIONS:

Please, give your list of medications to the front desk to make a copy OR write your medications here:

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ALLERGIES:____

Private insurance authorization for assignment of benefits and information release:
I, the undersigned, authorize payment of medical benefits to David Bjelica, MD for any services furnished to me. I understand I may be financially responsible for any amount not covered by my insurance. If requested, I also authorize you to release to my insurance company information concerning health care, treatment or supplies provided to me.
I also understand that the doctor's office reserves the right to automatically discharge me as a patient for any outstanding balances not paid within our 60-day grace period.

Signature: ____Date: _____________

Thank you!