Susan P. Epner, M.D.

PATIENT INFORMATION

Date: ___________ Referring Physician: ____ Phone: ____________

Patient Name: ____ Age: ________ Birth Date: __________ M F

Address: ____ Home Phone: __________ Cell Phone: __________

City: ______________________________ State: ________ ZIP: ________ Email: ______________________________

Patient SS#: __________________________ Drivers License #: ______________________________ State: __________

Employers Name: ____ Phone: ______________

Address: ____

Spouse Name: ____ SS#: ____________ Birth Date: __________

Employers Name: ____ Phone: ______________

Address: ____

In Case of Emergency

Nearest Relative not living with you: ____ Phone: ______________

Nearest Friend not living with you: ____ Phone: ______________

Responsible Party for this Bill: ____

Method of Payment: ☐ Cash ☐ Check ☐ Credit Card

INSURANCE INFORMATION

Medicare #: ______________________________________ Medicaid #: ______________________________________

Insurance Company: ____ Group #: ______________

Address: ____ ID #: ______________

____ Date of Injury: ____________

Insured's Name: ____ SS#: ______________

Group Insurance Employer Name: ____ Phone: ______________

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both pages and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify the billing office of any changes in my status or the above information.

Signature: ____ Date: ______________