Greg Heal, M.D.

Obstetrics • Gynecology

PATIENT INFORMATION *(Please Print)*

PATIENT'S NAME LAST	FIRST	MIDDLE INITIAL	HOME PHONE NO.	CELL PHONE	DATE OF BIRTH	AGE

STREET ADDRESS ☐ PERM. ☐ TEMP. (CHECK ONE)	SOCIAL SECURITY NO.	☐S ☐M ☐W ☐D ☐SEP MARITAL STATUS

CITY	STATE	ZIP CODE	MAIDEN NAME	RELIGION (OPTIONAL)

REFERRED TO OUR OFFICE BY:	OCCUPATION OF PATIENT (INDICATE IF A STUDENT) ☐ FULL-TIME ☐ PART-TIME

PATIENT'S EMPLOYER	BUSINESS PHONE NO.

EMPLOYER'S STREET ADDRESS	CITY	STATE	ZIP CODE

NAME OF ☐ SPOUSE ☐ PARENT, IF MINOR (CHECK ONE) BIRTH DATE:	OCCUPATION OF SPOUSE OR PARENT	WORK PHONE NO.

SPOUSE OR PARENT'S EMPLOYER	SOCIAL SECURITY NO.

EMPLOYER'S STREET ADDRESS	CITY	STATE	ZIP CODE

ADDRESS IF DIFFERENT FROM PATIENT:

INSURANCE INFORMATION *(Please List in Order To Be Submitted)*

PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY INSURANCE
NAME OF POLICY HOLDER	NAME OF POLICY HOLDER	NAME OF POLICY HOLDER
IDENTIFICATION NO.	IDENTIFICATION NO.	IDENTIFICATION NO.
GROUP NAME OR NO.	GROUP NAME OR NO.	GROUP NAME OR NO.

SPECIAL INSTRUCTIONS

PERSON RESPONSIBLE FOR PAYMENT, IF NOT PATIENT	STREET ADDRESS, CITY, STATE AND ZIP CODE	HOME PHONE NO.

1. PROFESSIONAL FEES: Fees for professional services are based on our own experience and not on payment schedules promoted by insurance companies as usual and customary, average, median, etc. In many cases, the entire fee will be paid by an insurance company; while in other cases, an insurance company will pay only a portion of the fee. We will furnish a reasonable number of medical and disability insurance reports to expedite your insurance claims. It is customary to pay for services when rendered unless other advance arrangements have been made.
2. FINANCIAL AGREEMENT: I hereby authorize payment of medical insurance benefits due me (my dependent) to be made directly to Dr. Heal. I understand that I am responsible for that portion of fees not paid by insurance.
3. RELEASE OF INFORMATION: I authorize Dr. Heal to furnish insurance companies, or their representatives, information concerning my (my dependent's) illness, injury, and/or treatment necessary for completion of claims for insurance benefits.

Date

Signature of Patient, Parent or Guardian