Current Visit/Insurance Patient Form

Lofton Misick, M.D.
819 Ayers St. Corpus Christi, TX 78404

Today's Date: _____/_____/_____

Patient's Name: _____
Last Middle First

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____Ext._____

DOB: ____/_____/_____ Gender: □ Male □ Female Social Security #: _____-_____-_____

Email Address: _____ Primary Source of Contact: □ Home Phone □ Cell Phone

Driver's License #:_____ Employer: _____ Work Phone #: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Whom May we call in Case of an Emergency? Name: _____ Relationship to Patient: _____

Primary Phone #: _____ Secondary Phone #: _____

Referring Physician: _____ Physician's Phone #: _____

Collection Policy: All payments are due at time of services rendered. This practice has a legal obligation to the insurance companies that we are contracted with to collect co-payments, co-insurance and deductibles at time of service. Once a balance reaches 90 days old without payment, it may be transferred to a third party for further collections or other actions. Due to the quantity and complexity of forms requested, there will be a $10.00 charge, payable in advance, for the completion of each of the first two forms requested. There will be a charge of $25.00 for all subsequent forms.

Canceling/Rescheduling An Appointment: If you are unable to keep your appointment, please notify our office at least twenty-four hours in advance to cancel or reschedule your appointment. Your courtesy will allow other patients needing exams the option to use your scheduled appointment time. Patients will be charged $25 for missed appointments unless the appointment was cancelled 24 or more hours in advance. Worker's Compensation patients will be personally responsible for this amount.

Patient's Initials: _____

***Primary Insurance Co.**: _____ Insurance Phone #: _____

Insured Name: _____ DOB: ____/_____/_____ SSN: _____-_____-_____

Patient Relationship to Insured: _____

Insurance ID #: _____ Group #:_____

***Secondary Insurance Co.:** _____ Insurance Phone #: _____

Insured Name: _____ DOB: ____/_____/_____ SSN:_____-_____-_____

Patient Relationship to Insured: _____ Insurance ID #: _____ Group #: _____