Elisabeth Huelskoetter, M.D., LLC

[ ] New patient [ ] Updated Form Patient #____________

(Please PRINT AND COMPLETE ALL INFORMATION)

Patient Information

Last Name ____________________________ First Name __________________________ Middle Name_______
Maiden Name__________________________ Social Security Number_______-_____-______
Address_____________________________ City_________________ State_____ Zip_______
Home Phone_(____)______________ Work Phone _(___)_______________ Cell Phone_(___)_____________
DOB____/____/_____ Age_____ Allergies___________________ Referred by________________
Marital Status: [ ] Single [ ] Divorced [ ] Married [ ] Widow [ ] Separated [ ] Life Partner
Spouse (or parent) Name ____________________________ Contact number______________________________
Patient's Place of Employment or School Attending__________________________________ Retired?: [ ] Yes [ ] No

Responsible Party

Person responsible for payment _____________________________ Social Security Number_____-_____-_____ Address ______
_________________________ City__________________ State_____ Zip________
Home Phone_(____)_____________ Work Phone _(___)_______________ Cell Phone_(___)_____________
Home Phone____

Primary Insurance

Insurance Company Name____________________________ Subscriber's Name__________________________
Subscriber's Relationship to Patient___________________ Subscriber's DOB___/____/_____
Subscriber's Employer_______________________________ Group #__________________________________ Patient ID #____
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Secondary Insurance

Insurance Company Name____________________________ Subscriber's Name__________________________
Subscriber's Relationship to Patient___________________ Subscriber's DOB___/____/_____
Subscriber's Employer_______________________________ Group #__________________________________ Patient ID #____
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Emergency Contact Information

Contact Name______________________________________ Relationship to Patient______________________
Contact Phone_(____)________________

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. If I fail to pay all bills or make payments as arranged I will be responsible for all collection and legal fees incurred by the medical practice necessary to receive payments. I authorize physician and/or clinic to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or Medicare benefits to be paid directly to the physician and/or clinic. I further agree that a photocopy of this document is to be considered as valid as an original

Patient/Guarantor Signature_______________________________________ Date______________________