❑ New ❑ Update

Kenton T. Bruice, M.D., P.C.

PLEASE COMPLETE EVERY FIELD

Date: ____/____/_____

PATIENT INFORMATION

Last Name _____ **First Name** _____ **Middle Initial** ____

Mailing Address _____ City _____ State ____ Zip Code _____

Home Phone: ( ) _____-_____ Date of Birth: ___/____/_____ Patient's Soc. Sec. No.: ____-___-_____

Sex: Male Female Is the *Patient*? Minor Single Married Is the *Patient* currently employed? Yes No

Employer: :_____ Work Phone: ( ) _____-_____ Ext._____ Cell Phone: ( ) _____-_____

If you circled Minor or Married, please complete the information below.

WE CAN DISCUSS THE ACCOUNT ONLY WITH THE PATIENT AND THOSE LISTED BELOW FOR MINORS

Parent #1/Spouse/Guardian Full Name _____
Mailing Address_____
City _____ State _____ Zip _____
Phone: (H) ( ) _____-_____
(W) ( ) _____-_____ Ext. _____
(C) ( ) _____-_____
Date of Birth: ___/____/_____
Soc Sec # _____-___-_____ Employer:_____

Parent #2/Spouse/Guardian Full Name _____
Mailing Address_____
City _____ State _____ Zip _____
Phone: (H) ( ) _____-_____
(W) ( ) _____-_____ Ext. _____
(C) ( ) _____-_____
Date of Birth: ___/____/_____
Soc Sec # _____-___-_____ Employer:_____

REFERRING PHYSICIAN

Patient's Referring Physician? Last Name _____ First Name _____ Phone ( ) _____-_____

INSURANCE INFORMATION

PATIENT'S PRIMARY HEALTH INSURANCE
Insurance Company _____
Ins. Co. Address: _____
City: _____ State: ____ Zip_____
Policy Holder: _____
First Name M.I. Last Name
Date of Birth: ___/____/_____
Soc Sec # ___-___-_____ **(required)**
ID # _____ Group #_____
Insurance Effective Date:_____

PATIENT'S SECONDARY HEALTH INSURANCE
Insurance Company _____
Ins. Co. Address: _____
City: _____ State: ____ Zip_____
Policy Holder: _____
First Name M.I. Last Name
Date of Birth: ___/____/_____
Soc Sec # ___-___-_____ **(required)**
ID # _____ Group #_____
Insurance Effective Date:_____

I authorize the release of any medical information necessary to process this claim and all future claims. I authorize payment of medical benefits to Kenton T. Bruice MD, PC. For these and all future services. I hereby authorize Kenton T. Bruice MD, PC. To disclose all medical records pertaining to the above named patient and hereby release Kenton T. Bruice MD, PC. From any liability therefore so long as such records are disclosed in confidence to a hospital, health maintenance organization, managed care organization, health insurance benefit plan, health care entity, professional liability carrier, pr peer review body, or the delegated agent or any such entity or body, to verify billing or for the purpose of conducting quality of care review, utilization management review, risk management review, peer review or other similar activity.

X _____
(Signed Insured or Authorized Person)