# Dr. Rebecca Clemenz, M.D.

(Please Print)

***The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.***

**Patient Information** **Date:** _____

Name_____
First Last M.I.

Address_____

Home Phone (__) _____ Work Phone (__) _____ SS#_____

Date of Birth _____ Age_____ Martial Status _____ Sex_____

Employer_____ Spouse_____

**Responsible Party ( *if different from patient)***

Name_____
Last First M.L.

Address_____

Home Phone (__) _____ Work (__) _____ SS#_____

Date of Birth _____ Sex_____

**Insurance Information ( *Please present insurance card at time of check in.*)**

**Primary** Insurance Name_____ **Secondary** Insurance Name_____

Name of Insured_____ Name of Insured_____

Insured's ID#_____ Insured's ID#_____

Group#_____ Group#_____

Insured's Date of Birth_____ Insured's Date of Birth_____

Relationship of patient to insured_____ Relationship of patient to insured_____

Employer Name_____ Employer Name_____

Other family members that are patients_____

In case of emergency, who should be notified_____ Phone_____
(Relationship)

Referred by:_____ Primary Care Physician:_____ Phone_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. In network insurance will be filed. Copayments are due at time of service. We accept payment in the form of cash, check or credit card. In the event your account must be turned over to collections, a $10.00 collection fee will be added to your account.

Patient's Signature

_____

The above is true and correct to the best of my belief.

If I am unable to accompany my minor child on subsequent visits, I authorize Dr. Clemenz to treat

_____

at her discretion. Your signature below signifies your understanding and willingness to comply with this policy.

Responsible Party's Signature Date

_____ _____