DATE ___________ **MICHAEL SUTPHIN, MD** ALLERGIES _________________

NAME __________________________________________________ SOC.SEC. # _____________________

ADDRESS ___________________________________ CITY ___________ STATE _______ ZIP ______

SEX-M ___ F ___ AGE ____ BIRTHDATE ________ SINGLE __ MARRIED __ WID__ DIV __ SEP __ HOME PHONE _______________

PATIENT EMPLOYED BY ____________________________________________ OCCUPATION _________________________

BUSINESS ADDRESS _______________________________________________ BUS. PHONE __________________________

SPOUSE'S NAME ____________________ EMPLOYER _________________________ SOC. SEC. # ___________________

FRIEND OR RELATIVE (NOT ALREADY LISTED _____________________ PHONE # ____________ ADDRESS __________

**PRIMARY INSURANCE**

PERSON RESPONSIBLE FOR ACCOUNT ___________________________ RELATION TO PT. _________________________

INSURED'S SOC. SEC. # ________________________________________ INSURED'S BIRTHDATE ____________________

ADDRESS (IF DIFFERENT FROM PATIENT'S) ________________________________________________________________

INSURED'S EMPLOYER _____________________________________________ OCCUPATION _________________________

BUSINESS ADDRESS _______________________________________________ BUS. PHONE __________________________

INSURANCE COMPANY ______________________________ INS. ADDRESS _____________________________________

CONTRACT # ______________________ GROUP # _________________________ SUBSCRIBER # _________________

**SECONDARY INSURANCE**

INSURED'S NAME _______________________ REL. TO PATIENT _________________ BIRTHDATE ____________

ADDRESS (IF DIFFERENT FROM PATIENT'S) _________________________ CITY _________ STATE ____ ZIP ________

INSURED'S EMPLOYER _____________________________________________ BUS. PHONE __________________________

INSURANCE COMPANY ________________________________________ SOC.SEC. # _______________________________

INSURANCE ADDRESS _________________________ CONTRACT # ____________ GROUP # __________ SUBSCRIBER # ___________

**ASSIGNMENT & RELEASE**

I, THE UNDERSIGNED, HAVE INSURANCE WITH _________________________ AND ASSIGN DIRECTLY TO DR. SUTPHIN ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

**(SIG. OF INSURED/GUARDIAN)** **(DATE)**

**MEDICARE AUTHORIZATION**

I REQUEST THAT PMT. OF AUTHORIZED MEDICARE BENEFITS BE MADE TO DR. SUTPHIN FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN. I AM RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NONCOVERED SERVICES. COINSURANCE & DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF MEDICARE CARRIER.

**BENEFICIARY SIGNATURE** **DATE**

**REFERRING PHYSICIAN/FAMILY PHYSICIAN** _______________________________________________________________