



Welcome To Our Office

Please PRINT the following information:

Patient Information

Date: _____

male
 female

Legal Name: _____
(Last) Mr. Mrs. Ms. (First) (Middle)

Date of Birth _____ Age _____ Social Security # _____ - _____ - _____

Address: _____
(Street) (City) (State) (Zip)

Phone (home) _____ (cell) _____

Employer _____ Work Phone _____

Child Single Married Divorced Referred By: _____

Family Doctor: _____ Referring Doctor: _____

Person Responsible for Bill

male
 female

Legal Name: _____
(Last) Mr. Mrs. Ms. (First) (Middle)

Social Security # _____ - _____ - _____ Relationship to Patient: _____

Address: _____
(Street) (City) (State) (Zip)

Phone (home) _____ (cell) _____

Employer _____ Work Phone _____

Insurance Company Information

Primary (1st)

INSURANCE _____ Policy Holder's Name: _____

Policy Holder's SS# _____ - _____ - _____ Policy Holder's DOB _____

Secondary (2nd)

INSURANCE _____ Policy Holder's Name: _____

Policy Holder's SS# _____ - _____ - _____ Policy Holder's DOB _____

Is your visit today related to: Workers Comp Yes No • Auto Accident Yes No • Liability Case Yes No

PLEASE READ: I hereby authorize CHRIS MASON, D.P.M., P.A. to release to your company or its representatives, any information including the diagnosis and the records of any treatment/examination rendered to me during the period of such medical or surgical care.

I understand and agree that I am financially responsible for any and all yearly or other deductibles, coinsurance, and any other services, procedures, or devices rendered to me which may not be covered under current health insurance plan(s). I further agree that I will pay for these obligations in full upon receipt of statement unless prior financial agreement has been made.

I also authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for Basic Medical, Major Medical and/or Surgical treatment for services, by reason of such treatment of services rendered to:

Signature of Patient

Signature of Insured

